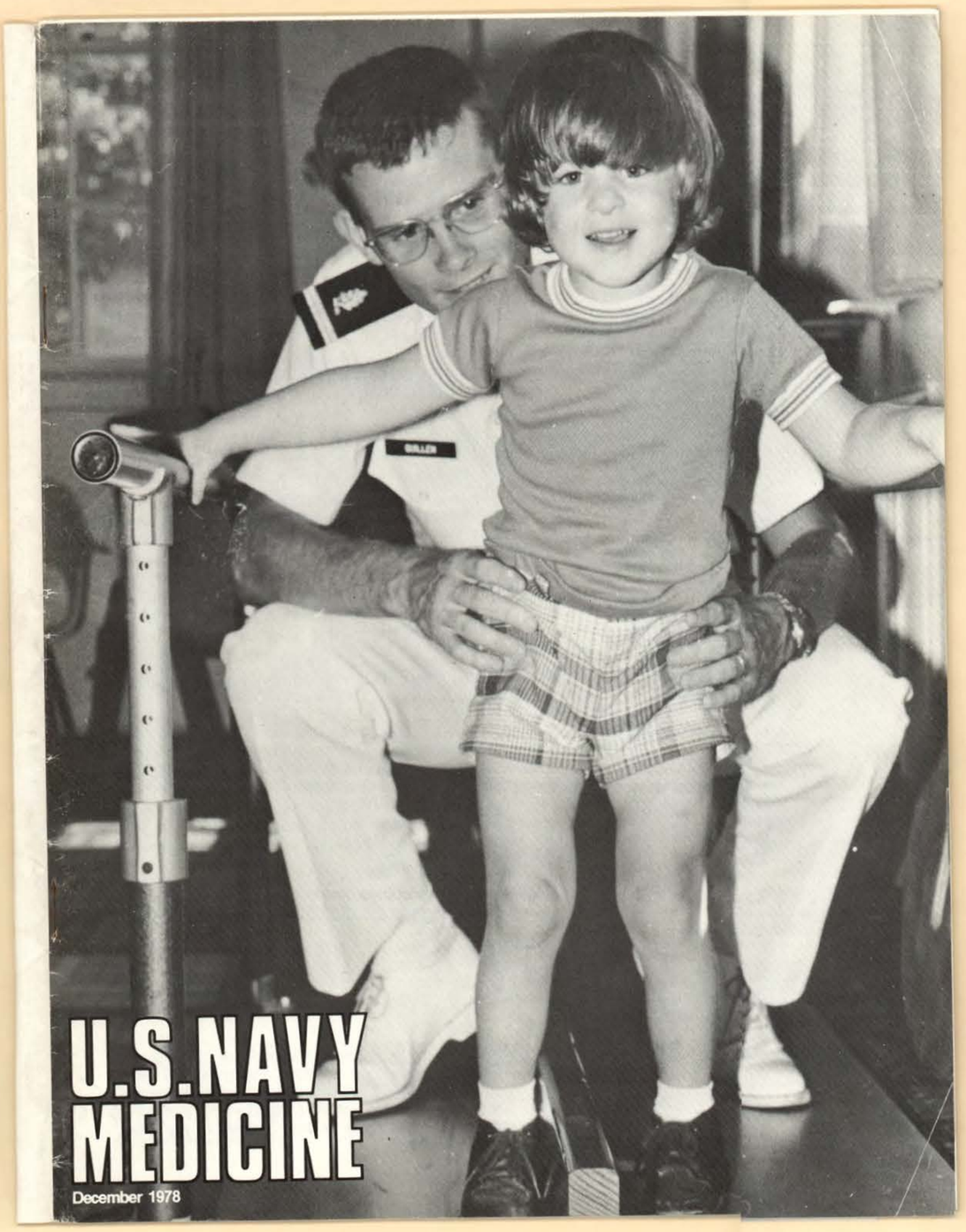
USMC photo by LCpl. David Trapp

MARINE CORPS BIRTHDAY BABY — Six-pound, eleven-ounce James Eric Brown doesn't know it yet, but he is the first baby born to a Marine family Nov. 10 here. James made his entry at the Naval Regional Medical Center at 12:55 a.m. on the 203rd anniversary of the founding of the Corps. His proud parents, Sergeant and Mrs. Roger Brown, accepted a layette from Carol Andrews (left) on behalf of the Navy Relief Society. Sergeant Brown is serving with Marine Corps Base.

ADVANCEMENT & AWARDS CEREMONY -
16 DEC 78

FIRST BABY BORN IN 1979
JANUARY 1979



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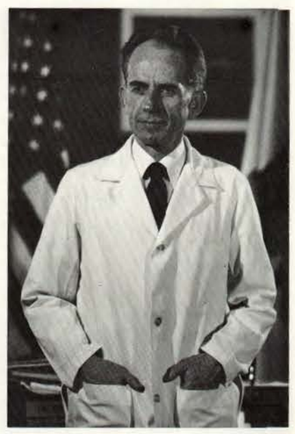
U.S. NAVY MEDICINE

Vol. 69, No. 12
December 1978

COVER: In the Developmental Physical Disabilities Clinic, part of the Physical Therapy Department at NRMC Camp Lejeune, N.C., LTJG William S. Quillen (MSC)—an ensign when this photograph was taken—helps a small friend with his navigation. For more about the clinic, see the article beginning on page 3. Photo by the NRMC Camp Lejeune Photo Lab.

Our Number One Priority



It is hardly possible to open a newspaper or magazine and not read an article or interview decrying the personnel shortages in military medicine.

I am besieged nearly every day by requests from the media for statements on the Navy's situation. Fortunately, although we are undeniably understaffed, I can report that our quality of health care has not yet suffered. Further, we seem to be doing better than our sister services in recruiting and retention.

Attracting and recruiting health professionals is an area over which the average Medical Department member has, realistically speaking, very little direct control. Everyone has a great deal of influence, however, in the area of retention.

We must concentrate our efforts and encourage those individuals who are qualified to remain as part of the Navy's medical team. Command career counselors are too frequently given little support or simply ignored. They must be allowed to be more active and begin playing a major role in our retention endeavors. Of course, to be properly effective they must be utilized. I urge everyone to contact a counselor, or return his call if he contacts you, before making a final decision to leave the Navy.

Peer group discussion is fine, but only when conducted in an atmosphere of truth. Unfortunately, all too often unfounded rumors are accepted as fact and can lead to what appears to be a sensible decision—one which, in reality, turns out to be far from correct. Remaining in the military is a decision only the individual and his family can make.

Retention is the CNO's number one priority and my number one priority. I'll do everything I can to improve the tangible aspects of life in Navy medicine. However, only with conscientious effort by everyone, from our commanding officers on down, will our personnel deficiencies be corrected.

Improving retention rates is simply good business. When you have good people you keep them. And I am glad to acknowledge that we have a lot of good people.

W.P. ARENTZEN
Vice Admiral, Medical Corps
United States Navy

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At NRMC Camp Lejeune, children with physical disabilities get . . .

A Little Help from Their Friends

Under the friendly eyes of Donald Duck, Winnie-the-Pooh, Tony the Tiger, and other familiar cartoon characters, a bright-eyed four-year-old is learning to walk between child-sized parallel bars. At two, he fell victim to bacterial meningitis. As a result, he is beginning the developmental sequence all over again.

The therapy room—colorfully decorated to attract and intrigue youngsters—is a part of the Physical Therapy Department at NRMC Camp Lejeune, N.C. It is the heart of a departmental initiative to help physically handicapped children start on the path toward a more normal life.

While the Developmental Physical Disabilities Clinic is only a small part of the department's total effort, it is a necessary one. "We felt there was a documented need to establish it," says LTJG William S. Quillen, MSC, USNR, one of the department's two physical therapists. (The other is chief therapist LT Gary Kremser, MSC, USN.) "Lejeune has around 37,000 active-duty personnel. There's a large dependent son-and-daughter population, and a good number of these children have some form of physical disability." However, because Camp Lejeune is located away from the larger population centers, civilian resources for the physical therapy these children need are not available within a reasonable distance.

The idea for the special clinic originated with LT Richard White, MSC, USN, formerly chief physical therapist at Lejeune, and now assigned to NRMC Memphis.

LT White felt that disabled youngsters, referred to the department by the medical center's orthopedic and pediatric services, should have a place of their own for therapy. "He got the ball rolling and did much of the legwork and ordering of equipment before he was transferred," says LTJG Quillen. The room designated for the children's use was renovated and redecorated last winter, and the clinic became fully operational this spring.

Equipment for the therapy room is simple but effective, and includes foam shapes for the children to handle and climb over, a Bobath ball, and the aforementioned pediatric parallel bars. Also part of the equipment—and incidentally one of

Photos by NRMC Camp Lejeune Photo Lab

Therapy can be fun. HM3 Laura Canepa turns a foam shape into a gentle slide.

For former ENS William S. Quillen, now LTJG, the goal is simple: to help this child develop basic physical skills that most youngsters take for granted.

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the most colorful features of the room—is a large, brightly colored carpet with a special purpose: it's a game rug, used with special game pieces for therapeutic play.

At any given time, the disabilities clinic has around a dozen youngsters under treatment. Their disabilities run the gamut, with cerebral palsy representing the most frequent problem.

The therapists' major work is to help the disabled child develop basic abilities—sitting, standing up, walking, feeding himself or herself, etc.—that the normal child takes for granted. Some of the youngsters work with a therapist once or twice a week, for sessions of 30 to 45 minutes; others, having achieved primary goals such as walking, come in less frequently for rechecks and monitoring of their progress.

Always, the therapists encourage parents to learn how to continue the children's therapy at home. Although the clinic cannot provide five-day-a-week care, "most of these children need daily therapeutic intervention," says LTJG Quillen. "The ones who make the greatest strides are those whose parents have really gone the extra mile."

The disabilities clinic is still in its infancy, he points out, and "we have to bring it carefully along and not overcommit ourselves." Once immediate goals for the disabled child have been achieved, the aim is to integrate him or her into the public school system or special education classes. "We're not taking over the role" of civilian institutions, he emphasizes.

The PT Department's two physical therapists and its four physical therapy and occupational therapy technicians handle a heavy case load, of which the Developmental Physical Disabilities Clinic constitutes only a small part. The department logs 1,200-1,500 patient visits per month—most of them by active-duty personnel—and the program for handicapped youngsters is made possible only by special effort on the part of department members.

"Because of our heavy workload," says LTJG Quillen, "if we didn't have good departmental cooperation—a total departmental effort—we couldn't offer this service."

An appealing environment is a vital ingredient in the children's therapy.

Notes & Announcements

Dental continuing education courses . . . The following dental continuing education courses will be offered in March 1979:

National Naval Dental Center, Bethesda, Md.
Complete Dentures 12-15 Mar 1979

Eleventh Naval District, San Diego, Calif.
Occlusion 12-14 Mar 1979

U.S. Army Institute of Dental Research, Walter Reed Army Medical Center, Washington, D.C.
Periodontics 5-8 Mar 1979

Armed Forces Institute of Pathology, Walter Reed Army Medical Center, Washington, D.C.
26th Annual Course in Oral Pathology 5-9 Mar 1979

Letterman Army Medical Center, San Francisco, Calif.
Periodontics 5-8 Mar 1979

Requests for courses administered by the Commandant, Eleventh Naval District, should be submitted to: Commandant, Eleventh Naval District (Code 37), San Diego, Calif. 92132. Applications for other dental continuing education courses should be submitted to: Commanding Officer, Naval Health Sciences Education and Training Command (Code 5), National Naval Medical Center, Bethesda, Md. 20014. Applications should arrive six weeks before the course begins.

AFIP courses offered . . . The Armed Forces Institute of Pathology will offer the following courses:

26th Annual Course in Oral Pathology 5-9 Mar 1979

This course is designed to provide dentists, physicians, and trainees in oral and general pathology with a fundamental knowledge of various aspects of oral disease, and to bring them abreast of recent developments in this field. It will be presented by specialists in oral and general pathology, oral surgery, dental research and cancer investigation. Developmental disturbances of the head, neck and oral region; inflammatory diseases of the oral mucosa and jaws; the oral manifestations of certain systemic diseases; and neoplasms of the oral cavity and related structures will be discussed in detail, and their clinical roentgenographic and microscopic characteristics will be illustrated.

Applicants should be members of the Medical or Dental Corps of the Armed Forces or other federal services. Qualified civilian personnel will be considered on a space-available basis.

Application of Histochemistry to Pathology 19-22 Mar 1979

This course consists of a survey of chemical and physical methods which can be used by the pathologist for the study of sections of tissue under the microscope. The subjects include a review of the theoretical basis of histochemical staining; the practical histochemistry of groups of chemical compounds such as carbohydrates, lipids, pigments and enzymes; and the histochemistry of particular organs such as the skin. The material will be presented by lectures, laboratory demonstrations, exercises, and the study of microscopic slides. Emphasis will be placed upon the use of equipment and methods suitable for the usual military laboratory of pathology.

Applicants should be members of the Medical Corps, Dental Corps, Veterinary Corps, Biomedical Science Corps, or Medical Service Corps of the Uniformed Services. Qualified civilian personnel will be considered on a space-available basis.

Further information may be obtained by writing to the Director, Armed Forces Institute of Pathology, ATTN: AFIP/EDZ, Washington, D.C. 20306.

Major requirement for MSC officers . . . Applications are being sought from qualified and highly motivated enlisted members on active or inactive duty for appointment in the Medical Service Corps, Naval Reserve for active duty. The following specialties are projected to have major vacancies during FY79:

- Health Care Administration
- Medical Technology
- Pharmacy
- Physical Therapy

A baccalaureate degree in the appropriate specialty is required. For further requirements, refer to the Bureau of Naval Personnel Manual, Article 1020130.

Medical film catalog updated . . . The HSETC 1974 Medical Film Catalog has been revised for 1978. The catalog contains approximately 500 film titles in all areas of medical expertise, including management. Most of these films are available in color in either 16mm film or ¾-inch videocassette tape. The latest program, completed too late for insertion in the revised catalog, is a research endeavor produced in cooperation with the Naval Medical Research Institute and is entitled, "Jim: A One Atmosphere Diving System" (T-469). The film demonstrates how Jim can function under working conditions pointing out the biomedical advantages of the system. It is recommended viewing for engineering and management personnel.

If you have not received your copy of the revised Medical Film Catalog, please call Autovon 295-1226 or write Audiovisual Resources Division, Code 26, Naval Health Sciences Education and Training Command, National Naval Medical Center, Bethesda, Md. 20014.

If you want to borrow materials from this catalog, contact your nearest audiovisual resources library or the HSETC audiovisual resources division.

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The Surgeon General's 10th Annual Specialties Advisory Conference and Committees' Meeting

This conference was held 12-15 Sept 1978 in Arlington, Va. The following report represents an edited (sometimes paraphrased or abbreviated) version of the remarks and presentations of specified individuals. Their comments do not necessarily reflect official views of the Navy Department or the naval service at large.

Most of the first plenary session of SAC X was covered in the November 1978 issue of this magazine. The following report covers the remaining presentations at the first plenary session and the second and final plenary session of the conference.

Graduate Medical Education and the Inspector General

RADM Melvin Museles, MC, USN
Inspector General, Medical
BUMED Code 007

First, I would like to talk to you about the scope of the Inspector General's responsibilities as a whole, and then speak more specifically about how I interface with you as chiefs of services, and with the graduate medical education programs in general.

I might start off very quickly by describing the "typical Inspector General." The typical IG is a man past middle age, spare, wrinkled, intelligent, cold, passive, noncommittal, with eyes like a codfish, polite in contact, but at the same time unresponsive, calm, and as damnably composed as a concrete post or a plaster-of-Paris cast: a human petrification with a heart of feldspar and without charm or the friendly germ, minus bowels, passion, or a sense of humor.

Now I hope that's not Mel Museles—at least that's not the image I'm going to try to bring to this assignment. I hope that the things I'm going to be doing this year will be done in a very constructive and instructive vein.

I would like to tell you a little about some of our objectives. Basically, we involve ourselves with command accomplishment of mission and functions; adequacy and management of available resources; organization efficiency and effectiveness (including compliance with directives and contingency planning); professional matters (quality of care, compliance with applicable standards, and training); staff appearance and grooming; and other items of special interest that are given to us, as the year progresses, by the Surgeon General—and perhaps by the CNO, passed down through the Surgeon General.

BUMED Instruction 5040.1B refines our inspection objectives and procedures as they apply to BUMED commands and provides some specific guidance for activities being inspected.

I am responsible directly to the Surgeon General and report to him after each trip. My team includes a Nurse Corps officer, CAPT Katie Zabel, who involves herself with many aspects of the inspection, but primarily with nursing service—quality of care being delivered on wards and in special care areas, such as emergency room, operating room, ICU, newborn nursery, recovery room, etc. CAPT Lloyd Nichols, my executive assistant, and CDR Ray Kessler, my administrative assistant, involve themselves with a lot of the administrative problems, including operating management services, budgets, supply, personnel management, safety, patient records, military records, facilities, equipment maintenance, etc. On our visits to the field, we occasionally augment our team with people from the Engineering Corps and Supply Corps who help us carry out the finer details of our assignment.

After an inspection trip, a formal report is made to the Surgeon General and to the commanding officer of the regional medical center. Our formal recommendations concern themselves with significant deficiencies, and major fiscal, personnel, or facility problems where outside assistance is required either from BUMED or from higher authority. These reports, of course, require very specific responses and follow-up action, usually within 30 days, and they have a very privileged status. Informal recommendations are also made directly to the commanding officer, and responses are required within 60 days. The Surgeon General is briefed after each trip on all recommendations, so that he is aware of what is transpiring in the field.

An IG inspection clearly could not be effective without adequate preparation. Prior to each of our inspection trips, we are involved in information gathering. We continuously keep abreast of current system problems, BUMED policies, JCAH inspection reports, Navy audit reports, and any changes taking place which would have an impact on the command we are about to visit.

I generally forward a pre-inspection letter to each commanding officer, requesting a wide variety of management information as well as data on specific problems which the command happens to be struggling with. Problems submitted by the activity become sources of special interest to me. We make personal visits to all the pertinent codes in BUMED, gathering more specific information about each command, and seek to assist with the problems they have identified, even before we go to the field.

If I am to inspect a graduate training hospital, I contact key people at HSETC and BUMED Code 3, in an effort to identify specific training problems in advance of my trip. I ask the following questions: Are they having difficulty with teaching staff? with their residents? with interns? with the teaching material? Are there future-assignment problems that perhaps I can help with? Are there additional space or support requirements currently not being met?

If I visit a command with a family practice teaching program, I will generally handle the program myself, since I personally have always had a special interest in medical education. However, if I inspect a very large graduate training hospital, I may request HSETC to augment my team with an additional physician to assist me in my interviews with residents, interns, teaching staff, and chiefs of services, because of the large number of people involved.

When I visit your centers, I am particularly interested in the following areas involved with your training programs:

- Your goals and objectives.
- Adequacy of your teaching material.
- Adequacy of your teaching staff. Are you well-balanced across the board and through all subspecialties?
- Quality of the teaching conferences within your own departments and within the entire graduate training hospital. Is the attendance sufficient? Is everybody getting what he or she is supposed to be getting out of these teaching conferences? How do you critique the teaching conferences? How do you plan to improve them? Is the conference approved for continuing education credits?
- Equipment. Is it adequate? Is it being maintained properly? Is it current state-of-the-art? What kind of planned replacement program do you have? Is there a command equipment review committee, and do you sit on it?
- Does your training program meet residency review requirements? (I try, whenever I can, to review previous residency committee inspection critiques to see if you indeed are correcting the deficiencies or problems defined by the residency review committees.)
- How well are the graduates of your programs doing with their board exams?
- How do you review, evaluate, and update your training programs?
- Your budget—Are your operating targets and your travel money adequate?
- Problem areas. In talking to your interns and residents, I generally turn up a lot of problems that may not surface with you directly. So we try to identify problem areas in which I may be able to help you with your program. I certainly can recommend additional support from HSETC and from BUMED where indicated.

I meet personally with as many of your residents and interns as I possibly can. I then meet with you and discuss my findings, attempting to do this, as I said before, in as constructive and instructive a manner as possible. I then discuss my findings with the commanding officer and keep him apprised of what's going on, on a daily basis.

At the end of our inspection, we generally hold a critique and invite as many of the staff to attend as possible. We go over our formal and informal recommendations with you all present. As mentioned earlier, the "formals" are those which generally require some support or assistance from BUMED or other higher authority. The "informals" are directed to the com-

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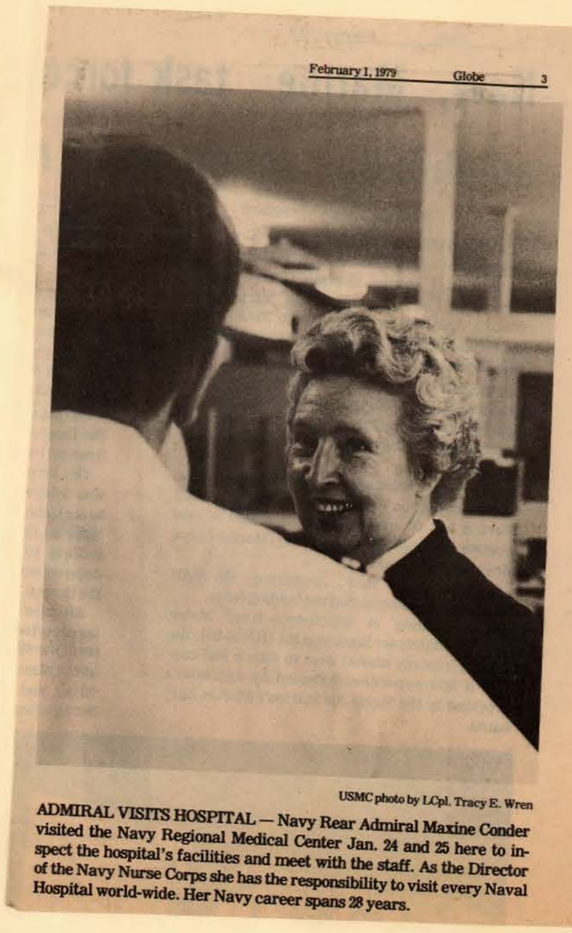

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RADM Museles

CAPT Richter

CAPT Castell

manding officer for his direct implementation.

Obviously, an IG inspection would not be effective without follow-on action. It is through emphasis on these critical "before and after" periods that the IG provides a continuous monitoring of Medical Department progress as well as motivation to improve local and BUMED support to the field, thus ultimately achieving improved quality of health care for our patients.

Although IG inspectors will always be plagued with those two great lies, "We're happy to have you" and "We're here to help you," I sincerely hope that in my tour this year these statements will be true.

My team is clearly designed to help BUMED carry out its mission of support to the fleet; to help commanding officers improve management; and to help you, as chiefs of services, improve your own graduate training programs.

The Uniformed Services University School of Medicine

CAPT Tor Richter, MC, USN
Associate Dean
Uniformed Services University of the Health Sciences

In this report on the status of the Uniformed Services University of the Health Sciences, I'd like to make three points: first, that the school is alive and well and living under an assumed name in Bethesda; second, that it is not just another medical school; and, third, that its success depends on just about everybody in this room.

To begin with, then, the school is a reality. For a time it appeared that it might remain an artist's conception. But since the dust settled on the congressional debate over the closing of the school a year ago last spring, the dust has been rising around the school's new buildings in the old Stone Lake picnic area in Bethesda. Classes have been conducted for the past year in the completed first increment and, with the completion of the entire complex next summer, the school will have classrooms, auditoriums, laboratories, and a library to support a medical school class as large as 175.

As there are no immediate plans for other schools of the health sciences, the institution has adopted the simpler name "Uniformed Services University [or USU] School of Medicine."

Three classes have been enrolled: a charter class of 31 students, just now entering their clinical years; a second-year class of 68; and a brand-new class of 108, fresh from a summer's orientation with their parent services.

Demographically, the students are pretty typical of freshman medical students elsewhere. There's a substantial number of women—approximately 20% of our applicants and our acceptees are female. We have a good, though not outstanding, percentage of minority students, and the college grade-point averages and MCAT scores are typical of those of students admitted to medical schools around the country.

But those of you who have been involved in the selection process know that we're looking for a student with another dimension: those personal qualities which will make them successful and happy in a military medical career. The components of those qualities, I suppose, are impossible to define, partly for the reason that standards for admission to the school embrace a great number of noncognitive as well as cognitive factors. In short, there are those who will be good clinicians, good teachers, be interested in what's going on around them, and be in the mainstream of American medicine. But there are also those who understand that commitment to military medicine goes far beyond that, and extends into the areas that you've heard described by previous speakers.

We're fortunate in having a large applicant pool. Last year there were nearly 3,500 applications for 108 places. We made 173 offers to fill those spaces, and of those 173 five were medically disqualified.

This year, though it's early in the application cycle, there are more than 1,000 applications in the office, and we expect the total to exceed 4,000—this in a period of declining medical school applications nationwide.

The school projects an ultimate class size of 175 and an average of 16 years of service from each graduate as a medical officer. If these projections are realized, approximately a quarter of the present medical officer billet strength within the armed services will be met by USU graduates.

The curriculum is long and densely packed, in the preclinical years, with lectures and laboratory. The standard array of subjects is presented, with emphases and modification to prepare the graduate (insofar as training can prepare one) for patient care in a military setting, including combat. The classroom routine is leavened, and identification with operational elements of the student's service strengthened, through summer electives.

In the summer following the first year, students are sent to operating units, usually in capacities which have nothing to do with their medical training. They become platoon leaders; go to jump school; work in shipyards and the like. The following two summers are spent in service medical activities, in research, and then in clinical electives. For some, this includes the opportunity to work in laboratories and hospitals throughout CONUS, and even overseas.

Of the nearly 450 USU faculty members, only 70 are full time, and of these only 23 are military officers billeted to the School of Medicine. Hence, the vast majority of the faculty is made up of volunteers whose primary duties are outside the school. Included are approximately 100 Navy medical officers.

Many of you have faculty appointments and USU medical school contacts. But it's only the beginning. As the trickle of students entering their clinical years becomes a flood, there will be a corresponding increase in medical officer-student interchange. And this will go on not only at Bethesda but at the other hospitals which participate in student teaching.

We are interested in your ideas about teaching our students and in your evaluation of their performance, particularly as it might affect the modification of our curriculum. We're new, and we're anxious to learn.

The role of the university in graduate and continuing medical education is presently small, but will grow. Potential areas of expansion include sponsorship of fellowships, which we are just getting into; conduct of continuing medical education, both in our own facilities, when they're completed, and elsewhere on request; and provision of guest speakers and visiting faculty to military health care activities as required.

Although I'm a little too close to the institution to be an objective observer, it seems to me that—beyond all I've said—the school has a symbolic function as well. I'd like to think that the existence of the school and its dedication to excellence is an inspiration both to those of us who are lucky enough to be there and to those who are so intimately involved in the Navy training programs. I hope that you'll think of USU as something you have an active interest in, and that you will assist and participate in its growth.

The Physician Personnel Shortage in Navy Medicine—An Invitational Address

CAPT Donald O. Castell, MC, USN
LTJG Margaret M. McCarthy, MSC, USNR
Internal Medicine Service
National Naval Medical Center

In his article "Medical Care: Health Needs and Resources" (*New England Journal of Medicine,* 1 Jan 1964), George Rosen appropriately stated that "the provision of health care requires sufficient numbers of competent personnel and appropriate kinds and numbers of facilities. The strategic factor is *personnel,* since no program of health care can operate without enough people of the right kind. A shortage of personnel can be defined simply as the difference between the numbers available to render service and the numbers needed."

Although need is often the index of adequacy in health-related discussions, the measurement of health care needs for the purpose of determining future personnel requirements is a complex problem with many interrelated variables. William L. Kissick, in an article entitled "Health Manpower in Transition," suggests that "in many areas need is determined by a highly judgmental process. How many times does a patient with hypertension or with well-controlled diabetes need to see a physician? With a definite answer to questions like these, a definite *need* could be defined for a specific amount of health manpower.

"Economists and manpower specialists agree that manpower forecasts based even on a finite need for future health services are unrealistic. They suggest approaching manpower forecasting in terms of demand for health services in the classic economic sense of supply and demand. Demand is the economic expression of need, although demand may go beyond need, as is the case with the hypochondriac."

Health manpower requirements blur the difference between need and demand. They may mean primarily

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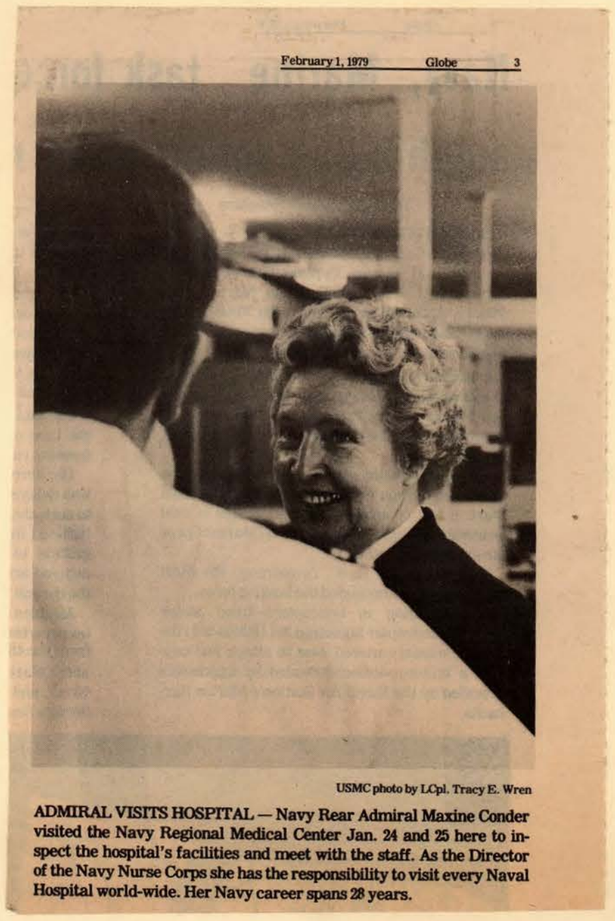

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TABLE 1: Estimated Navy-Wide Subspecialty Requirements

	Ideal	Reasonable	Minimum	Actual 1979 Staffing Estimate
Cardiology	43	37	29	16
Hematology/Oncology	39	30	26	17
Infectious Disease	44	37	17	6
Pulmonary Disease	23	18	16	14
Gastroenterology	29	22	14	12
Endocrinology	22	19	14	10
Rheumatology	26	21	9	7
Nephrology	8	6-8	6-8	7

need or mainly demand, or they may mean a mix of need and demand. A review of the literature on the projection of health care manpower requirements results in an unclear distinction between need and demand. Although the prediction of manpower requirements for the provision of health care services is risky, it is an essential step in organizational planning.

A severe physician shortage is one of the major problems that faces the Navy Medical Corps today. This is a problem most Medical Corps officers are concerned about. It is a problem in organizational planning, requiring the attention and talents of high-level administrators. Although the shortages are not painfully apparent at the four major training centers this year, the projections by specialty consultants for the summer of 1979 indicate that there will be severe and critical shortages of physicians of all specialties, resulting in training-program deficiencies, limited patient accessibility to specialist care, and an unavoidable overall decrease in the quality of medical care.

With the discontinuation of the draft in 1973, there has been a progressive decrease in Berry Plan input. Consequently, the Medical Corps is presently on its own in terms of the acquisition of physicians, particularly qualified specialists and subspecialists. With this "no input" situation, the Navy Medical Corps must *train to meet its needs.* To establish a rational plan for present and future training programs, an intelligent appraisal of the true needs for physicians of all specialties in the Navy Medical Corps is necessary.

In order to examine the seriousness of the problem more closely and give thought to its resolution, we gathered data on the availability of, and requirements for, internal medicine subspecialists throughout the Navy.

Methodology. Various forecasting methods for determining health manpower requirements are cited in current literature. All have unique deficiencies. The use of one method over another usually depends on the data that are readily available. More often than not, a combination of various methods is used in an analysis of future health manpower needs.

The three most cited methods are:

- Population ratios. The application of existing health-manpower-to-population ratios to the projected population base.
- Economic projections. The formula involves (1) projecting the expenditures for future years and using this figure as the numerator; (2) determining the expenditures per worker and using this figure as the denominator. The result translates effective demand into manpower requirements.
- Professional judgment. The use of medical professional opinions in the absence of hard data.

Of the three methodologies cited, we used the third: professional judgment. Data which would allow us to use the population ratio methodology and/or the economic projection methodology were unavailable.

We gathered our data by soliciting opinions from internal medicine physician subspecialty advisors relative to their estimates of projected need in the individual subspecialties. In each instance, the consultant was asked to survey a complete list of Navy hospitals and give his best judgment of placement and numbers of subspecialists, based on "ideal," "reasonable," and bare "minimum" staffing levels.

The study was limited to the specialties of internal medicine because of the co-authors' knowledge in this area, but it was felt that the shortages in internal medicine were but a reflection of those in other specialties. We used the subspecialty of cardiology as a specific example because the needs in this critical subspecialty seem clearer.

Table 1 gives an estimate of Navy-wide requirements for each of the eight subspecialties in internal medicine, presented as "ideal," "reasonable," and "minimum" needs. Quite striking are the comparisons with the projected July 1979 resources in each subspecialty, which fail to meet even the "minimum" staffing estimates.

Table 2 indicates the estimated personnel needs in the subspecialty of cardiology for the four teaching centers, the naval regional medical centers, and the remaining Navy hospitals, presented as "ideal," "reasonable," and minimum" requirements. The table indicates that if only the "minimum" estimate is satisfied, many of the medical centers, and most of the remaining Navy hospitals, will not have a cardiologist on board. The grand totals in these estimates indicate that "minimum" staffing needs supply primarily only the four teaching centers. Resource estimates for the other seven medical subspecialties show a similar distribution.

Before we could further examine subspecialty needs, we needed to develop a formula to predict the number of trained subspecialists on active duty at any time. When examining the numbers of trainees completing their subspecialty programs per year, we made three professional judgment assumptions:

1. The average period of obligated service at the completion of fellowship is two years.
2. The Navy can anticipate a 25% retention rate on active duty after the obligated two years.
3. Those subspecialists retained beyond the two years will remain active in their subspecialty for ten years.

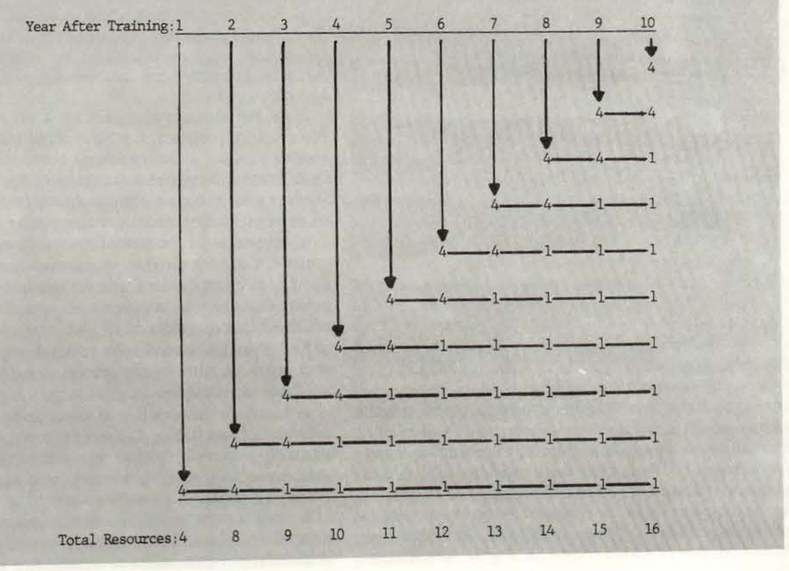
Obviously, many factors can modify each of these assumptions, but experience would suggest that they are reasonably accurate. At present, many physicians completing a two-year subspecialty fellowship have only a one-year obligation to remain on active duty, and many are leaving the Navy at the completion of that year. However, this trend is changing, and longer periods of obligation at the completion of fellowship training are becoming more common. The assumption of a 25% retention rate beyond the period of obligated service is probably generous. In addition, the assumption of retention for ten years of active involvement in a particular subspecialty is probably also a generous estimate.

Based on these assumptions, Figure 1 indicates the projected numbers of specialists on active duty at any

FIGURE 1

SUBSPECIALTY MANPOWER RESOURCES PER YEAR

BASED ON TRAINING OUTPUT OF 4 PER YEAR



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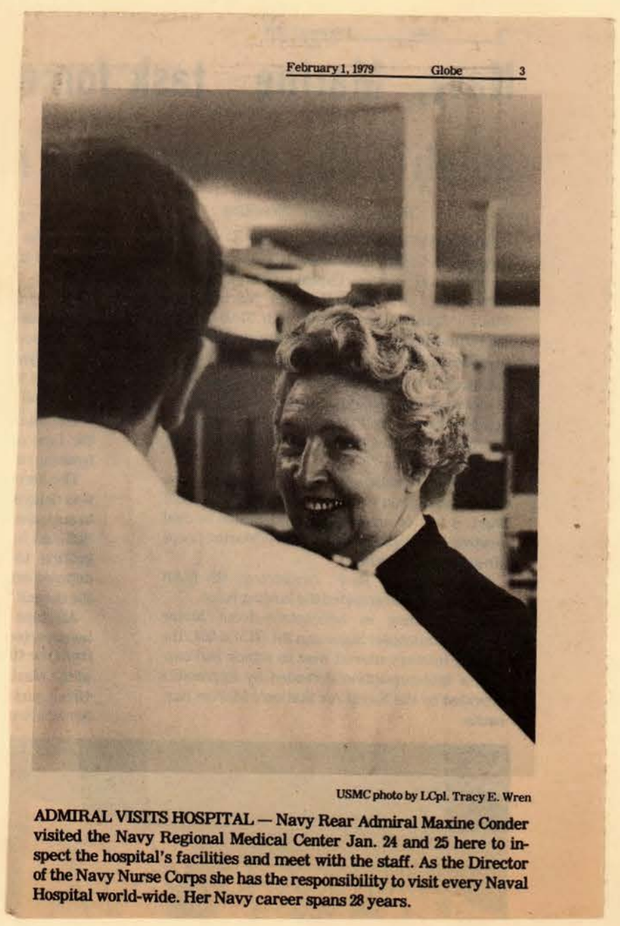

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TABLE 2: Estimated Number of Cardiologists Required by Hospital

	Ideal	Reasonable	Minimum
Teaching Centers:			
Bethesda	5	5	5
Oakland	3	2	2
Portsmouth	4	4	4
San Diego	10	8	7
	22	19	18
NRMCs:			
Newport	0	0	0
Subic Bay	0	0	0
Bremerton	1	1	1
Camp Pendleton	1	1	1
Charleston	1	1	1
Great Lakes	1	1	1
Guam	0	0	0
Hawaii	0	0	0
Jacksonville	1	1	1
Long Beach	1	1	0
Memphis	1	1	0
Philadelphia	2	1	1
Yokosuka, Japan	1	0	0
Camp Lejeune	1	1	1
New London	1	1	1
	12	10	8
Hospitals:			
Annapolis	1	1	1
Beaufort	1	1	0
Cherry Point	1	1	0
Corpus Christi	1	1	1
Guantanamo Bay	0	0	0
Key West	0	0	0
Lemoore	0	0	0
Orlando	1	1	1
Patuxent River	1	1	0
Pensacola	2	1	0
Port Hueneme	0	0	0
Quantico	0	0	0
Roosevelt Roads	1	1	0
Rota, Spain	0	0	0
Taipei	0	0	0
Whidbey Island	0	0	0
	9	8	3
Grand Totals	43	37	29

time, resulting from a training program providing an output of four subspecialists per year. Again using cardiology as an example, assumption number 3 indicates that at the end of the tenth year one subspecialist per year will be lost to retirement or upward mobility, so that the total number remains constant beyond that point. Mathematically, a fixed ratio then develops, based on the numbers shown in Figure 1, indicating that for each subspecialty trainee output per year there will be four subspecialists on active duty at any one time.

Table 3 lists the current numbers of approved training billets each year in the various subspecialties in internal medicine, as recently revised by BUMED Notice 1520 of 1 May 1978. Note the small number of trainees in all subspecialties, e.g., only four per year in cardiology and two per year in infectious disease. As indicated earlier, with the decrease in the Berry Plan input, the Navy is in a "no input" situation. The Navy, at this point, is entirely dependent on subspecialists generated in the Navy system. Also, only 30 general internists are presently being trained each year. Using the formula for projected total manpower, this would indicate only 120 internists on active duty at any time, far below our estimated need of approximately 292 total internists. (This is a 1978 projected-need figure from the "professional judgments" of the commanding officers of all naval hospitals.)

The discrepancy between our current training potential and our estimated needs can be better demonstrated by Table 4. Here the "minimum" staffing requirement in each subspecialty is shown, together with the number of trainees required per year to maintain this level on active duty. The deficit between the number of trainees required and the number of trainees currently provided is striking. Remember, this is the "minimum" staffing estimate.

Conclusions. From the above analysis, the following conclusions can be drawn:

1. Accurate data with which to define rational needs for military health care resources are difficult to obtain. Until more accurate data can be obtained, "professional judgment" may remain the most reasonable technique to use.

2. In the absence of a military draft and the Berry Plan type of program, the Navy must train to meet its needs.

3. Present Navy training programs are not providing the Navy health care system with even the "minimum" number of internal medicine subspecialists (Table 4).

4. Alternatives for providing the Navy health care system with at least the "minimum" number of subspecialists must be immediately examined in order to prevent severe compromises in the quantity and quality of health care provided.

Recommendations. There are at least four ways to change the formula for the provision of subspecialists in the Navy Medical Corps:

1. Increase the number of years spent practicing a subspecialty after completion of fellowship training. It seems highly unlikely that this will be accomplished, and in fact, as stated previously, the estimate of ten years is probably a generous one.

2. Extend the obligation for subspecialty training beyond two years. This trend appears to be occurring. With increasing numbers of scholarship students, and

TABLE 3: Subspecialty Fellowship Positions Each Year by Naval Activity

Internal Medicine Subspecialties	Positions Each Year	Bethesda	Oakland	Portsmouth	San Diego
Internal Medicine	30	6	4	8	12
Cardiology	4	2			2
Endocrinology	2	1	1		
Gastroenterology	2	1			1
Hematology/Oncology	3	1			2
Infectious Disease	2	2			
Nephrology	1				1
Pulmonary Disease	4	1		1	2

Source: BUMED Notice 1520 of 1 May 1978

TABLE 4: Comparison of Minimum Subspecialty Requirements with Current In-Service Training Output

Subspecialty	Minimum Staffing Requirement	Yearly Output Requirement	Current Output/Year	Deficit (Trainees/Year)
Cardiology	29	7	4	3
Hematology/Oncology	26	6-7	3	3-4
Infectious Disease	17	4	2	2
Pulmonary	16	4	4	0
Gastroenterology	14	3-4	2	1-2
Endocrinology	10	2-3	2	0-1
Rheumatology	9	2	0	2
Nephrology	8	2	1	1

eventually Uniformed Services Health Sciences University students, completing subspecialty programs in the future, we should recognize an increase in periods of obligation for subspecialists. But this offers no hope for the immediate short-term needs.

3. Improve retention. Navy training centers are presently facing severe deficiencies of experienced senior teachers. The alarming loss rate of commanders having 10-15 years of active duty has resulted in great voids in many training programs. There seems to have been little or no progress in reversing this trend.

4. Increase the input of subspecialists into the Navy medical system.

In lieu of drafting physicians, which would solve the Medical Corps problem, and recruiting subspecialists, which has been a relative failure, the final recommendation seems to be the most expeditious way to resolve the present critical situation. It would seem that serious consideration should be given to finding whatever mechanism is available to increase training in medical subspecialties. Every attempt should be made to increase inservice subspecialty training where present resources allow, but the projected deficiencies of subspecialists by July 1979 will make it difficult for training programs to be staffed adequately.

The alternative to inservice training would be to increase outservice training. Based on the foregoing analysis, this is highly recommended, particularly in those subspecialties that are most crucially affected, such as cardiology, hematology, and infectious disease. The benefit of such a maneuver is much greater than the simple provision of increased numbers of subspecialists. One of the major strengths of a teaching hospital is the association with colleagues from various schools and training programs. Outservice input would prevent "inbreeding."

Finding the mechanism for increased outservice training with appropriate added obligations for active duty should be considered a high-priority item and a crucial need.

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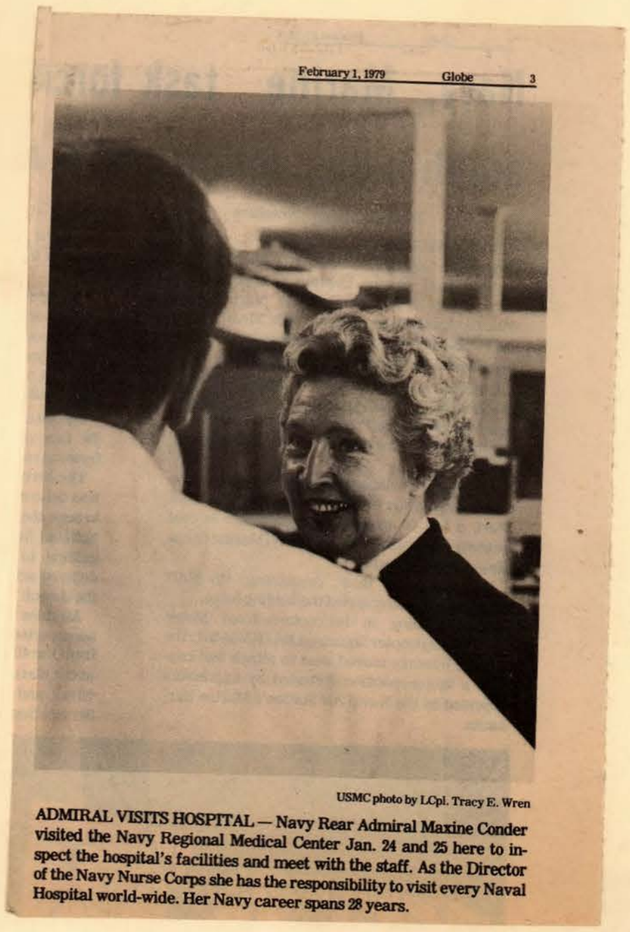

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Introductory Remarks

CAPT J.S. Cassells, MC, USN
Director of Clinical Services
NRMC San Diego, Calif.

This has been a very good meeting. The consensus generally has been that there is a strongly positive spirit this year. The pall of gloom that has sometimes passed over us in recent months is beginning to lift. For the first time in a long time at these meetings, there has not been a great clamor of people wanting to present issues for the consideration of this august body. There are issues to be addressed, all right, but they appear to be soluble issues, and that's a definite step in the right direction.

Our first speaker is LCDR Richard Ridenour, from the Intern Directors Committee. All questions will be held until the end of the speakers' presentations, and then they will be addressed by VADM Arentzen and his staff at that time.

Intern Selection

LCDR Richard I. Ridenour, MC, USNR
Director of Interns
NRMC Portsmouth, Va.

The Intern Directors Committee would like to report the following statistics to you regarding the selection of Navy scholarship students for GME-1 positions in the areas of family practice, obstetrics and gynecology, basic medicine, basic surgery, pediatrics, and psychiatry.

Navy scholarship students' preference lists showed 323 applicants for 255 GME-1 positions set aside for graduating medical students. In obstetrics and gynecology, there were 32 applicants for 18 positions; in family practice, 56 applicants for 38 positions. Basic medicine had 146 applicants for 105 positions. In basic surgery, there were 61 applicants for 73 positions; in psychiatry, 6 applicants for 11 positions; in pediatrics, 22 applicants for 10 positions.

Of those assigned to basic medicine internships, 85% got their first choice for both programs and location. Of those assigned to basic surgery internships, 78% got their first choice for program and location. All other programs showed fairly equally high percentages as relating to program and location choice.

The intern directors unanimously and strongly urge consideration of the following three proposals:

1. Navy scholarship students selected for Navy internships should be given, at the beginning of the GME-1 year, a complete list of operational medicine and GMO billets to which they could possibly be assigned, following that GME-1 year, if they are not selected to continue in training and/or do not wish to continue in training. This would greatly aid in the interns' personal planning during the year and would allow them to explore their options fully.

2. Whenever possible, scholarship students requesting deferments for residencies in specialties in which the Navy is experiencing important shortages should be granted a full deferment, so that the Navy may have the advantage of their serving their obligations in those specialties. These decisions will take into full consideration the operational needs of the Navy.

3. We strongly recommend that Navy scholarship students applying for Navy internships be required to have at least one interview with a Navy medical officer, that medical officer preferably to be located at a training center. More than one interview is recommended.

We ask that the chiefs of services and training directors stress in their correspondence with students the importance of a personal interview in the selection process for internship. Should it be decided that this interview cannot be *required,* then we recommend the use of appropriately strong wording, in the internship brochure and other literature, suggesting the desirability of this type of interview.

This year there were a significant number of applicants unknown to any of the programs. Not having an interview placed the candidate at a serious disadvantage, particularly in highly competitive programs. It seemed to us that many applicants who preferred to take civilian internships seemed to avoid interviewing, possibly feeling that this would give them a better chance for deferment because they might not be known —and, therefore, not selected. Some applicants could not be rated for selection because of incomplete folders, often without interviews.

We acknowledge that the interview may cost the student time and cause him or her monetary inconvenience, but we feel that the benefits to the student and to the Navy in the selection process far outweigh these other issues.

The Operational Tour

RADM Henry A. Sparks, MC, USN
Deputy Surgeon General and
Assistant Chief for Headquarters Operation

The Operational Medicine and Research Development Committee took under consideration some 15 agenda topics for review and analysis. We selected for presentation one important subject around which much of our personnel planning and utilization revolves: namely, the operational tour.

VADM Arentzen addresses a question from the floor.

It is the recommendation of the Operational Medicine and Research Development Committee that *all* GME-1 graduates, without exception, be assigned to operational billets. This recommendation is made with the full realization that this policy will have a potentially negative impact, for one to two years, on graduate medical education programs.

The institution of such a policy would, we believe, provide for the introduction of operational medicine into career planning of all junior medical officers at the most appropriate time; improve the acceptability of operational assignments as career enhancing; and improve the performance and prestige of Medical Corps personnel with the line community.

Adherence to such a recommended policy would have to be tempered, of course, with appreciation of several hard facts, one of which is current accessions.

GME candidates number about 300. There are slightly over 600 operational billets, which require an input of approximately 300 personnel per year to maintain readiness on a continuing basis. Approximately 250 GME-2 postgraduate positions are available in all specialty disciplines per annum. At the moment, qualified active-duty applicants from the operational arena are selected to fill approximately two thirds of those 250 billets.

With the implementation of a uniform policy with respect to a mandatory first tour in an operational assignment, approximately one third of the graduate-level positions would remain vacant for one to two years. Now, that is the *immediate* prospect. But if we take into consideration the numbers that were projected on prospective accessions from the medical scholarship program, it doesn't take too much reflection to recognize that the circumstance will turn around completely within 36 to 48 months when the number of new accessions will go up significantly. Then we will have the problem of providing enough training billets for those physicians who have completed the operational tour.

With respect to our recommendation, we offer it with the full realization that this is a complex issue; however, we stand by the basic premise that there should be a 100% involvement in an operational tour following completion of GME-1 training.

Technical Support

CAPT James K. Summitt, MC, USN
Chief, Ophthalmology Service
NRMC San Diego, Calif.

When Dr. Cassells asked me to address this particular topic, I hesitated because I was afraid that the information I have might be a little inaccurate, and that I would say some things that someone in the audience could contradict. But I think the numbers that I can give you this morning, at least with regard to ocular technicians in ophthalmology and optometry, will suffice for some of the issues we ought to look at.

While I'm going to be talking specifically about ophthalmology and optometry, I recognize that almost all the specialties that use technicians will have similar, and probably worse, problems. I'm going to address San Diego specifically, because that's where I'm located.

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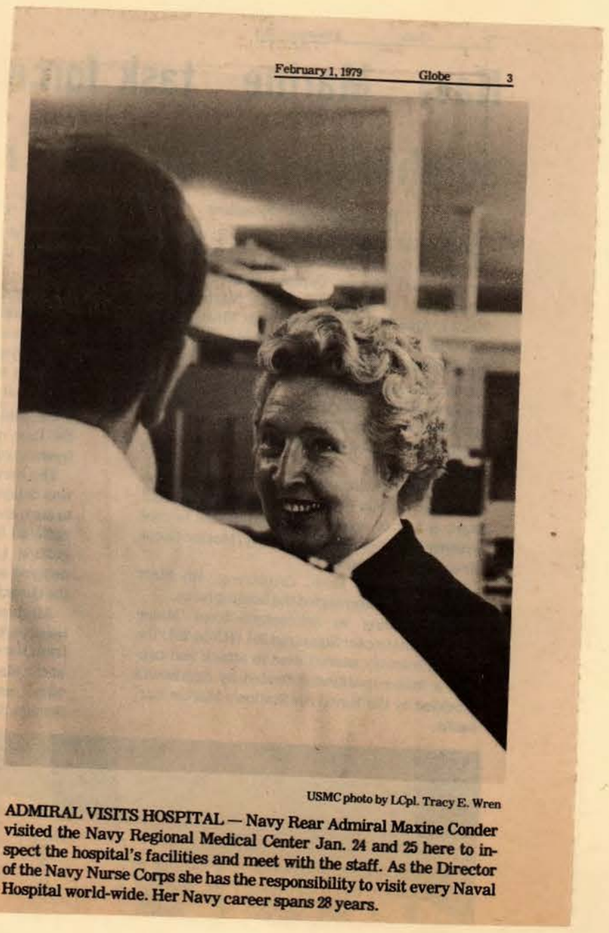

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VADM Arentzen introduces RADM Williams (left), retiring Deputy SG.

As all of you know, San Diego is a large regional medical center. The Ophthalmology Department runs eight clinics and three operating rooms—frequently simultaneously—scattered over six military bases.

We have an authorized ocular technician level of 30. But in February 1978 our onboard strength was 16, and for several months we had to restrict our surgery, stop routine leave, and underman the regional clinics. The number of technicians has subsequently increased to 23, but we're scheduled within the next four or five months to go back to 17 or 18.

I don't have any doubt that some of these technicians will be replaced, and the personnel documents that reflect these changes will reflect the losses considerably before they do the gains. But, in any case, I think that we look forward to another period of several months of marginal capability. From talking to the other chairmen in my group, I think they are going to go through a similar period.

Let's take a very brief look at the ophthalmology and optometry technicians in the Navy overall. We have approximately 182 authorized technician billets, with a current onboard strength of 158. This sounds pretty good—it's a shortfall of only about 25. But in the next 15 months, we predict a loss of 97 technicians and a gain of only 71.

The replacements that we expect are going to come both through the training cycle and through reenlistments. It's interesting that, in the predictions I could acquire, only 12 of those replacements are coming from reenlistments, and I think that again emphasizes the extreme importance of our efforts to keep our enlisted personnel in the Navy.

In addition, we have raised questions as to whether the billet numbers scattered around the Navy are adequate, even if they are manned 100%. We recognize that there are a number of ways of determining the ancillary personnel that are legitimate for support of the professional officer, and it's a complex issue. In some instances, it might best be done by taking an individual unit workload, such as a laboratory or an X-ray facility. In some specialties, such as dentistry or ophthalmology, and probably ENT, it might best be determined on the basis of the number of individual practitioners, and I understand that such a system has in fact been proposed and submitted to the Surgeon General for consideration in the field of ocular techs. This model assumes, also, that not only do you have the professional manpower that is supported by the technician manpower, but you also have facilities that are designed for the maximum utilization of both doctors and corpsmen.

Finally, there is a problem not only of numbers but also of quality and distribution. Ocular technicians are divided into two groups: clinical technicians, who support the ophthalmologist and the optometrist in the clinics, and surgical technicians, who work both in the clinic and in the operating room—but they are extremely vital in the surgical suite.

Today we have an onboard strength of 125 clinical technicians, but we have only 33 surgical technicians. It's not too difficult to see that surgical technicians may not be available for all facilities, particularly the smaller hospitals that support one or two professional officers.

I have been told that both Memphis and Yokosuka will be losing their surgical technicians this fall, with no replacements planned, and most certainly this is going to impact on their ability to do major ocular surgery. Even the larger hospitals, such as Philadelphia and Bethesda, are so tightly staffed with surgically trained technicians that unexpected leave or illness results in modified or canceled surgical schedules.

We recognize that the solutions to these problems are not simple, and they'll take some time. But I personally am convinced that the people here in Washington are well aware of our problems and are working very hard to help solve them.

I would propose that those of us who have been at this meeting take two steps on our own. The first one is to go back home and keep our enlisted people in the Navy, if we can. And the second is to document our own workloads and our own activities so that we can give the information to the people back here, to justify the needs that we know are real.

Travel Funding

CAPT Richard Davis, MC, USN
Chief, Anesthesiology Service
NRMC Oakland, Calif.

A goodly percentage of you are program directors, and while this originally was an anesthesiology problem, I think it affects several of you.

The American Board of Anesthesiology has a biannual program directors' meeting which is not held in conjunction with any national meeting but is instead held at the annual assemblage of the board members for oral board exams.

This year they have requested both the program director and the clinical competency chairman to attend. The board doesn't trust us to be totally honest about our residents, so they require that somebody besides the program director say this physician is actually competent. Thus, they requested that two of us from each program come to the meeting.

The meeting is a workshop-type meeting—thus it's both an official and an unofficial exchange of information. They solicit our opinions about proposed changes in board requirements, and they give us off-the-cuff information which may or may not ever come out in an official fashion. The meeting gives us an opportunity to get to know the board members, and for them to get to know us, on a somewhat personal basis. This, in the past, has proved of value when there have been problems with board applications or problems that needed a little personal intervention.

The only trouble this year was that nobody had any money for travel. The departmental funds were relatively spent, and we were not in a position to fund travel for two additional people. I went to the command and was able to get some money for this, but the command was in a bind because they had spent all their money. HSETC was solicited and was broke, so the problem we were faced with was how to pay for this meeting. Some of the Navy anesthesiologists were going on their own, on authorization orders; small amounts of money were pried out of various sources for other physicians.

In the past, HSETC has funded this. I thought it was done on an official basis, but it turns out that it was done if there was money left at the time the application came in. This year, for various reasons, the money wasn't available.

Our proposal is that there should be an obligatory funding mechanism of some sort. One of the logical ways to look at this is that it is an integral part of the residency program. It is just as important for the program director to go to the program directors' meeting, and thus keep his residency program viable, as it is for the resident to take his integral-part rotations and thus keep his residency viable.

Education Up the Line

CAPT Calvin Early, MC, USN
Chief, Neurosurgical Service
NNMC Bethesda, Md.

We as program directors, as teaching chiefs, expend boundless energy in the education and training of our trainees, our attending staffs, and ourselves. But how much effort do we expend in the education of our commands, our Bureau, the CNO, and on up the line?

I think it is abundantly clear that unless we are capable of, and effective in, educating up the line, we will not long be successful in fulfilling our mission—either our peacetime mission of patient care for our beneficiaries or our contingency mission.

Is it not possible to educate our superiors so that they can understand and accept the fact that it may be necessary to provide a certain resource—be it materiel or

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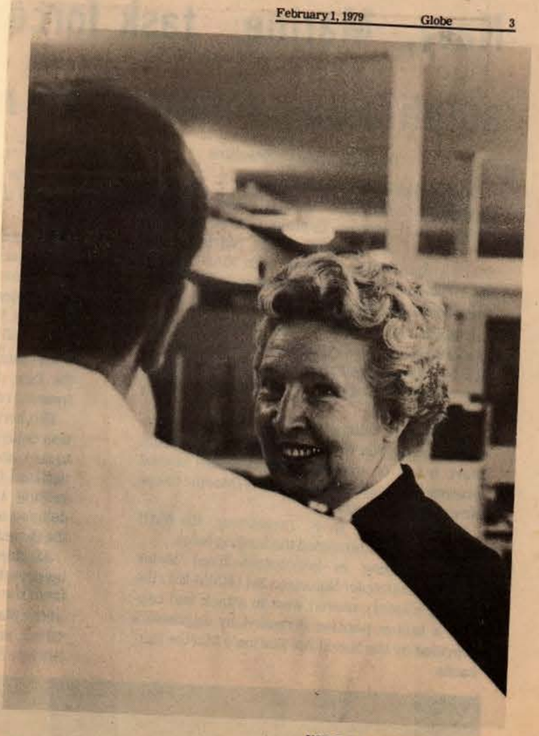

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CAPT Early

CAPT Siemmons

personnel—in peacetime, so that another resource—e.g., a neurosurgeon—might be available for the contingency? In the general practice of neurosurgery at the present state-of-the-art, a surgical microscope and many microsurgical instruments are absolutely mandatory. But they are unnecessary— and in fact they are essentially useless—in war neurosurgery. I can guarantee you, however, that unless they are provided, you will not have one single neurosurgeon worth his salt on the line to treat the battle casualty when the need arises.

The example I have given involves materiel—microsurgical equipment—but is the intellectual step from materiel to personnel so difficult? Can we not educate the powers-that-be to the fact that it may be absolutely necessary, in the peacetime situation, to have certain personnel who may have no significant direct role in the contingency situation, in order to have on the line a neurosurgeon or some other person who is absolutely necessary for the contingency, when that contingency comes?

We have been told there is a document that states that all billets must have a contingency function. A document is a piece of paper. Thinking mem can tear up pieces of paper—even the Constitution can be amended. Documents should exist to aid in the solution of a problem, not to enslave men so that they cannot effect solutions.

Take billeting documents, for example. They exist to provide a solution to a problem. If the problem changes, or ceases to exist, or if a better solution is found, the billet should be changed to meet the new situation.

Too often we find ourselves trying to mold our solution to fit the billets. Clearly, this is putting the cart before the horse.

One of my staff neurosurgeons recently spent six weeks shipboard—he was one of the last medical officers to be so assigned under the fleet pool concept. He is very career oriented, and I encouraged him to volunteer for this assignment. When he returned, he told me of about 20 corpsmen he had observed who were assigned to the Marines—X-ray techs, lab techs, other critically needed clinical personnel. He saw them essentially wasted, while both before and after his cruise he saw patient care seriously faltering because of lack of such personnel.

Can't CMC and BUPERS be educated to preclude such waste? Can they not be shown that providing clinical care now, rather than sitting on their duffs shipboard, does not detract one fig from our corpsmen's ability to perform in the contingency?

Many of us on the front line of clinical care believe that BUMED has no higher, no more important task than this education up the line. We hold that unless this effort is reasonably successful, our work in our training programs and clinical centers, and our efforts in conferences such as this one, will bear little but rotten fruit. Indeed, without such education even our most sincere efforts to meet our contingency responsibilities are also doomed to failure.

We on the front line of clinical care and training recognize that education up the line is not the Bureau's only responsibility. Certainly, goal direction, regulation, and monitoring of patient care are among its many responsibilities. But we contend that we clinicians are well enough grounded in our jobs that we really require very little regulating, and we view education up the line as a function of the Bureau which is more vital to fulfilling the mission of the Medical Department, contingency or otherwise.

At many of these SAC meetings, we have often been given charges. I think that now we, the clinicians, charge you, the Bureau, with this responsibility of education up the line.

I conclude, then, with three questions: Where, in the rank order of relative priorities, does the Bureau place the function of education up the line? Are those up the line educable? How effectively is the Bureau now carrying out this responsibility, and what are the prospects for the future?

Orthopedic Staff Shortages

CAPT B.K. Siemmons, MC, USN
Chief, Orthopedic Service
NNMC Bethesda, Md.

At the last SAC meeting, the Orthopedic Committee projected a 53% reduction in orthopedic staff positions by 1979. We felt that this would necessitate reductions in provided services and should not occur at the expense of training programs. We recommended elimination of orthopedic positions at 11 facilities and reduction in the number of orthopedic surgeons at 16 other sites, amounting to a total reduction of 42 billets.

As of July 1978, there were eight hospitals that did not have orthopedic surgeons: Cherry Point, Guantanamo Bay, Key West, Lemoore, New Orleans, Patuxent River, Quantico, and Whidbey Island. In 1975, the SHORSTAMPS people did a study of the orthopedic community and recommended one orthopedic surgeon at Cherry Point, none at Guantanamo Bay, one at Key West, one at Lemoore, none at New Orleans, none at Patuxent River, two at Quantico, and one at Whidbey Island. The SAC Orthopedic Committee came up with the same figures. That leaves us now with a deficit of six orthopedic surgeons and with eight facilities that do not have orthopedic surgeons.

Based upon projected losses, by July 1979—and certainly by October 1979—five additional hospitals will lose their entire orthopedic staff. Beaufort will lose two; Corpus Christi, two; Okinawa, two; Port Hueneme, one; Roosevelt Roads, one. The SHORSTAMPS people recommended that to cover these five hospitals we need 20 orthopedic surgeons, while the SAC committee recommended 14, with a bare-bones minimum of 11. So by July 1979, 13 hospitals will not have orthopedic surgeons assigned, and there will be a deficit, in these hospitals, of 26 orthopedic surgeons from the SHORSTAMPS recommendation and 17 from the SAC committee's bare-minimum recommendation.

In July 1979 or shortly thereafter, based on projected losses, the following 10 hospitals will each have one orthopedic surgeon remaining: Philadelphia, Guam, Charleston, Great Lakes, Memphis, Subic Bay, Rota, Yokosuka, Naples, and Newport. The SHORSTAMPS people recommended that these hospitals should be staffed with 34 orthopedic surgeons. Our SAC committee recommended a bare minimum of 28, leaving these hospitals with a deficit of 18 from the committee recommendation.

Five hospitals will have two orthopedic surgeons each after July 1979: Bremerton, Camp Lejeune, Long Beach, New London, and Annapolis. The SHORSTAMPS recommendation for these five hospitals was 26 orthopedic surgeons. The SAC committee recommended a bare minimum of 19, which will leave a deficit of nine from the committee recommendation.

As of July 1979, three hospitals will have three orthopedic surgeons each: Jacksonville, Orlando, and Pensacola. SHORSTAMPS recommended that these hospitals should be staffed by 19 orthopedic surgeons. The SAC committee recommended 14, leaving a deficit of five from the committee recommendation.

One orthopedic program is better off than most others—that at Camp Pendleton, where there will be four orthopedic surgeons. But even there the SHORSTAMPS people called for an orthopedic staff of 10. Our committee felt they could probably get by with six, which means a deficit of two from our recommendation.

At the orthopedic residency training program hospitals, the staffing, after July 1979, will look like this: Bethesda, three; Oakland, four; Portsmouth, four; San Diego, five. The SHORSTAMPS recommendations were nine for Bethesda; for Oakland, at least six; for Portsmouth, eight; for San Diego, nine.

The SHORSTAMPS study, then, recommended that the total staffing of Navy orthopedics should be 147. Our SAC committee felt that we could operate, at a bare-minimum level, with 114.

Onboard strength in July 1979 will be 48. This leaves us a deficit, from even our bare-minimum recommendations, of 66 orthopedic surgeons. Now that does not include the 11 graduating residents, so if we add those 11 to the 48, we will have a total of 59. There will be 11 residents, then, to fill 66 billets.

Now, as to priorities, we still feel that we cannot allow our residency training programs to go downhill. If qualified staff were transferred from other hospitals to training programs, this would include transfer of a man from Memphis, transfer of a man from Yokosuka, and transfer of a man from Charleston. If, in addition to this, one of our prospective candidates for reentry into Navy orthopedics is successful, and if six of the 11 graduating residents are kept in training programs as staff, then our training programs remain viable.

But the second priority, as I see it, is our overseas hospitals, which have no other resource for orthopedic

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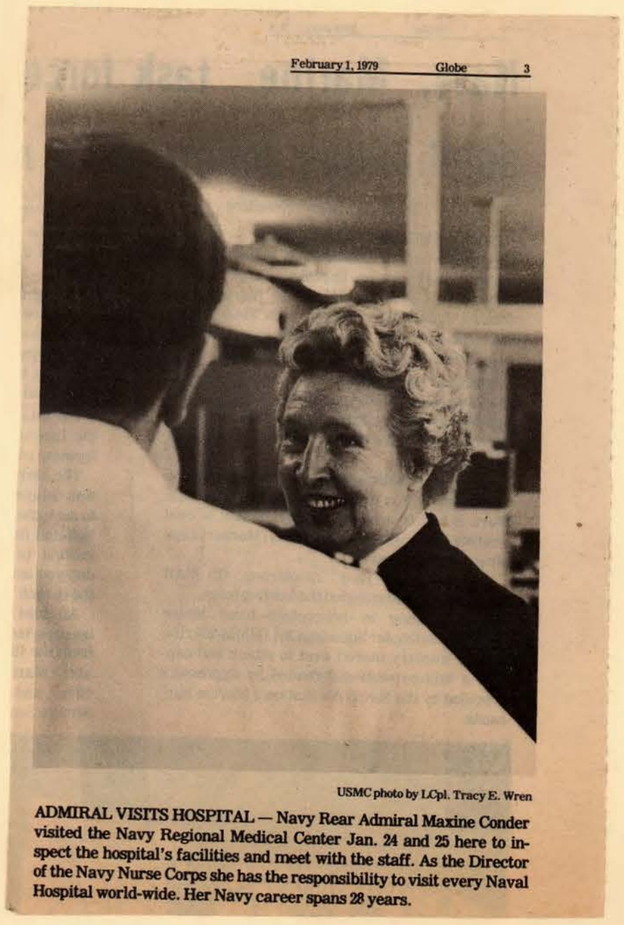

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care. The five remaining residents who are finishing in July 1979 could fill orthopedic billets at Yokosuka, Okinawa, and Roosevelt Roads, but we would be adding Charleston and Memphis to the list of non-staffed hospitals.

Now a few additional comments:

• There is an orthopedic need to defer medical scholarship students for outservice training in much greater numbers. But until the Uniformed Services University provides input into our residency applications, the deferments must be selective and identified as early as possible, so that those medical students may apply and accept civilian residency positions.

• We are in deep trouble in our ability to provide orthopedic care to active-duty personnel at important naval facilities. General surgeons are going to be called upon, more and more, to provide this care, and a greater burden is going to be placed on the operational and family practice physician. Are those people receiving adequate training for this in their training programs?

• Members of the SAC Orthopedic Committee are firmly opposed to contracting with civilian orthopedic surgeons to provide care to active-duty personnel. There are a number of reasons we feel this way, and I think all you have to do is reflect on what contracting has done to cost, morale, and retention when other specialties have been forced to go that route.

The Future of SAC

CAPT J.S. Cassells
Director of Clinical Services
NRMC San Diego, Calif.

The Directors of Clinical Services Committee was given, in addition to the task of circulating among the various committees here at SAC, the charge of addressing the issue of SAC itself. Should it continue? If it continues, what format should it take?

Historically, SAC developed as a mechanism to allow training-program directors some say in the selection of the trainees assigned to them. Over time it has acquired another function: the establishment of a dialogue—the giving and receiving of information in both directions, between the Bureau and the field. A significant side benefit has been the opportunity to gain access to key people for discussion of our local problems and the opportunity to discuss with our peers similar or different problems in our own facilities.

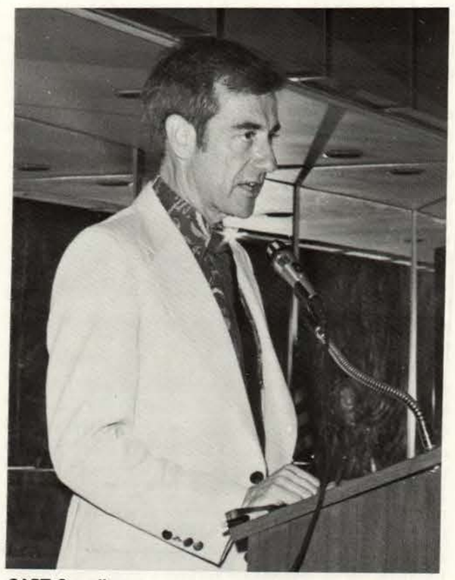
As valuable as this is for those of us here, it is incumbent upon us to carry that information back with us and to disseminate it, not just to the CO's office but throughout the command. I had not realized, until I went to San Diego, how very small the window on Washington is, and it's not just the three-hour difference. I'm looking at SAC from an entirely different perspective this year.

Our committee has agreed unanimously that SAC most certainly should continue. SAC is expensive, but I think it is one of those circumstances where we cannot afford to save the money. The same general format appears to work well and should be continued.

We do feel that participation ought to be expanded to include some representatives from outside the eight graduate training hospitals, and some additions should be made from within those institutions.

We are concerned that the teaching requirements and capabilities of staff assigned to family practice training programs are not always very well addressed. At a minimum, we would like to see two non-family-practice specialists from those four hospitals attend SAC, for the dual purpose of helping in the family practice selection process and, even more important, sitting with their own specialty groups in order to emphasize the legitimate staffing needs and special requirements of their departments in those family practice training hospitals.

Another issue that we addressed, although we were not charged to do so, relates to the junior officers. While those of us in this room are, generally speaking, savvy enough—and, more significantly, senior enough



CAPT Cassells

CAPT J.J. Quinn responds to a question put to the discussion panel. At right: RADMs Sparks and Williams.

—to get the information we need in some way, that is not generally true of our younger colleagues. It is our responsibility, of course, to transmit information to them. But there is nothing like occasionally getting it from the horse's mouth. A number of alternative approaches to that problem—beginning with bringing a few of the junior officers to SAC—have been suggested. There is also the suggestion that we conduct workshops—one on each coast, perhaps—for junior officers.

It is true that it is the young medical officers outside the graduate training centers who have the greater problem. The military sections of the various specialty societies offer an approach, but that is obviously not the total solution. We have had that mechanism in force for some time now.

Each of us on our committee has a different opinion as to how to accomplish this goal. But accomplish it we must, because—make no mistake about it, my friends—unless we do something about communicating better with our younger colleagues, this room will be empty in a few years.

I began this morning's session by stating that I felt there had been a more positive atmosphere at this year's SAC. I continue to believe that. My idea of a "pall of gloom" is a situation where there is no solution. I think that we are not in that kind of position this year. I think solutions to our problems are possible by the exercise of common sense and reasonableness. I believe in my bones, as I've said before, that this system of ours can accommodate anybody's reasonable request.

DISCUSSION

VADM W.P. Arentzen, MC, USN: Let's quickly go through a few of the issues that have been raised:

Scholarship students: providing the list of billets when they start out—that's no problem.

Interview by at least one medical officer at the training hospital—I think that's a good suggestion and should be implemented as soon as possible.

Deferments granted, if possible—Well, of course that's been one of my long-range plans: to defer as many as humanly possible. Shortly after I took over, I realized that all of our Medical Corps scholarship student billets were not filled—because, I was told, "we didn't think we would need them." They're all filled now, and I'd like to get more billets and defer a minimum of 200 a year to get training on the outside, to stop the inbreeding and to ensure us a good supply of trained people.

I couldn't disagree with Henry Sparks more when he says underfill our residency training program by one third. I just can't conceive of that—the only thing keeping us together is

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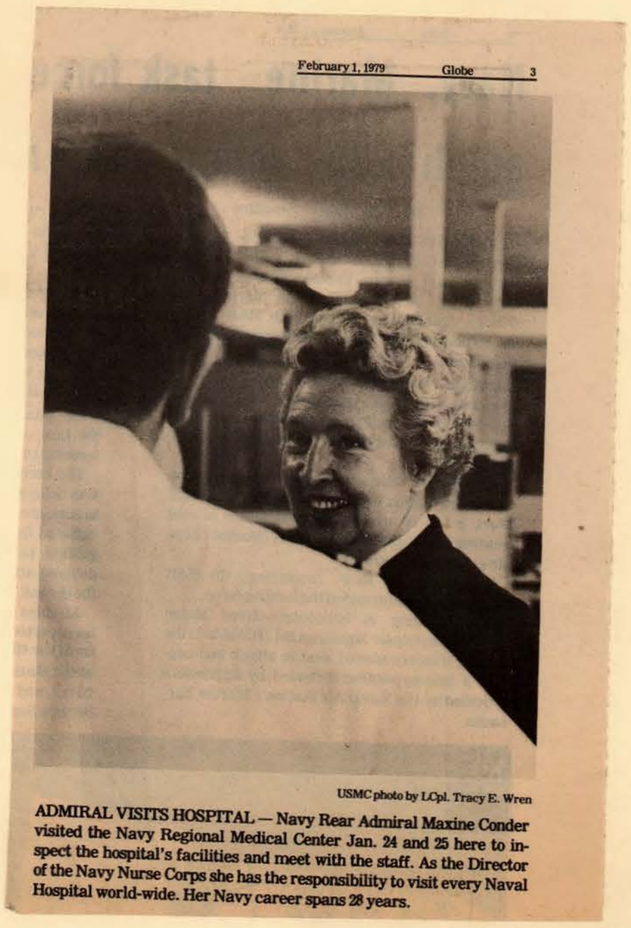

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our training program. I realize that we have a commitment to the operational forces—we'll meet that commitment—but we're not going to cut back on our training programs. That would be absolute suicide, and everybody in this room, I'm sure, would be leaving as soon as he or she possibly could.

We have a line credibility, and we're getting more all the time. The OP-093 hat the Surgeon General now wears gives us free access to the CNO and to all the deliberations over in the Pentagon. That never happened to us before.

When I meet with the CNO in our daily morning conference —that's where we educate these people to our needs. At the VCNO's conference, where all the "three stars" are, and the other admirals over at the Pentagon—that's where we can educate them as to our needs. But we don't have to educate them that much; they know our needs.

You must realize that they, too, are strapped, the way we are. They're short, right now, close to 6,000 enlisted. Another angle of that is that the pool of people available for enlistments is decreasing each year.

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our training program. I realize that we have a commitment to the operational forces—we'll meet that commitment—but we're not going to cut back on our training programs. That would be absolute suicide, and everybody in this room, I'm sure, would be leaving as soon as he or she possibly could.

We have a line credibility, and we're getting more all the time. The OP-093 hat the Surgeon General now wears gives us free access to the CNO and to all the deliberations over in the Pentagon. That never happened to us before.

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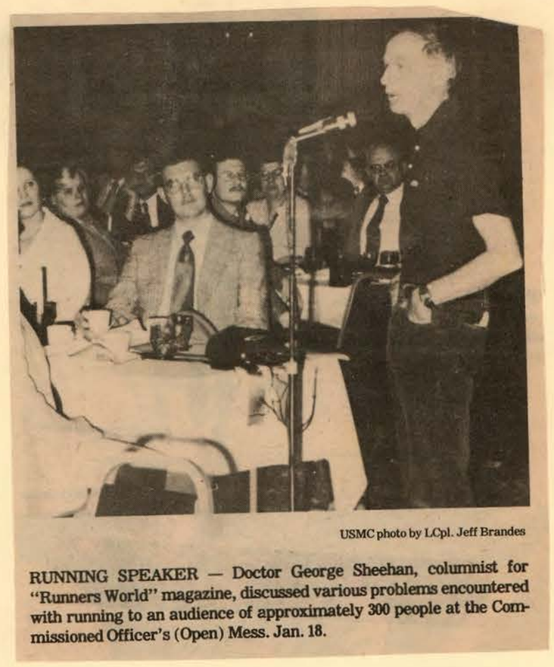

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spent their travel floor, this will reflect in their fitness reports, I can assure you.

We must have every dollar we get for travel used for conference travel. That's such an important thing to every one of you here, and to all the residents and everybody else, and this year that travel money will be increased.

I made a trip out to WESTPAC in the spring, and I found rather a lot of discontent among our dentists and physicians because they are stuck over there for 42 months, in some cases, with no chance for travel. I intend to increase their travel dollars, so that at least once during their tour, they'll have a chance to come back to a professional meeting.

CAPT P.D. Nelson, MSC, USN: I would like to say something in direct support of our Surgeon General's leadership and emphasis on the importance of training.

In the Medical Service Corps today, we face many of the problems I've heard you discussing here this week. We are undergoing many changes also, and if I and the staff that I am bringing to the Medical Service Corps directorate do our job within the next year or two or three, then I think a decade from now we're going to see the greatest change in the Medical Service Corps structure, professions, and quality of our people that we have ever seen. Continuing education, not only for early professional development but for midcareer shifts in professional emphasis and job requirement, will be emphasized, as seems the case in the innovative concepts RADM Barchet and his staff at HSETC are developing.

I would ask each of you, in your important roles as leaders, to stress the concept of leadership among our Medical Service Corps officers as well as our up-and-coming physicians, dentists, nurses, and hospital corpsmen. We call upon you also, within the priority structure of budgeted funds for travel and continuing education, to consider the Medical Service Corps, along with the Medical Corps, Dental Corps, Nurse Corps, Hospital Corps—the entire Medical Department structure—as *all* being vital in this continuing education process.

RADM P.E. Farrell, DC, USN: I think recruiting is such an important issue that we should all give our utmost attention to it—not just recruiting of our officers, but of our enlisted people as well. For too long, we have given lip service to this. And I think that, as has been said before this morning, you are each going to have to spend some time and sincerely talk with your personnel, and try to get them to stay with us.

Another thing I think is so important is that we have to be a little more compassionate and show a little more care and concern for our patients. I think we should renew our dedication to all our eligible beneficiaries: our active-duty personnel, our dependents, and especially our retired personnel. We will do what we can for our own people—take care of our own.

VADM Arentzen: I have used the circumstances of certain medical officers as an example in testimony to Congress. As a result, for the first time they have realized that pay inequities do exist, and as soon as possible they will try to correct them.

We have 269 medical officers now who have served 20 years plus. This is my grave concern as I look around this room. We can't just replace you overnight—we must keep you—and we have to find ways to make you want to stay in and to keep our training programs going.

I have just a few more comments. I'd like to mention the medical school—USUHS. I am very anxious to press the medical school to have on its staff some of our teachers from locations other than Bethesda. I want to get some from the West Coast and all our teaching hospitals. I've told Jay Sanford, the dean, that I will pay the transportation and per diem to bring anybody that he appoints to the staff to Bethesda for a week, two weeks, a month—whatever he wants. I feel this is an incentive to all the good physicians throughout the Navy, and I intend to press that with Jay.

Another thing about USUHS—use their talents. They have a tremendous group of basic sciences people over there, and Jay Sanford is willing to send them all over the country to do some teaching, so make use of them.

About the Medical Service Corps—I'm getting most concerned about the loss of superbly trained young MSC's. They see a bottleneck at the top; they don't think they're appreciated that much by the Medical Corps. There are lots of these young fellows I would like to keep in the service, so take a little interest in them also.

I'll just wind up by asking you to stay with us, because if we lose any great number of you fellows in this room, some of our teaching programs will go down the tube. I'm not going to have a training program run by somebody who has just finished his residency, without any experience, without a gray hair on his head, so think twice before you put your papers in to retire or resign. We're working on getting you more incentives to stay in when you've reached 20 years. And if you want to stay clinical, well, then, just stay clinical. If you want to stay at a place, we're going to let you stay as long as we possibly can.

I'll end by saying thank you for your contributions this week. We'll take everything you said into our deliberations and do our best to make the Navy Medical Department just a little bit better.

Thank you very much.

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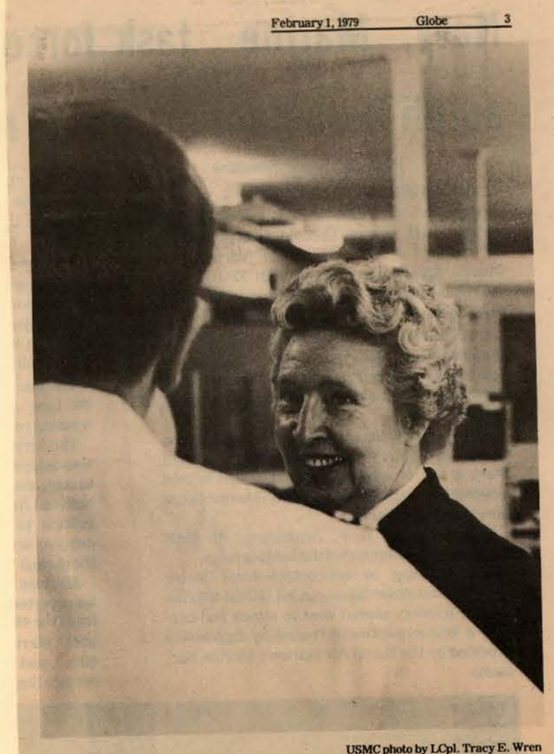

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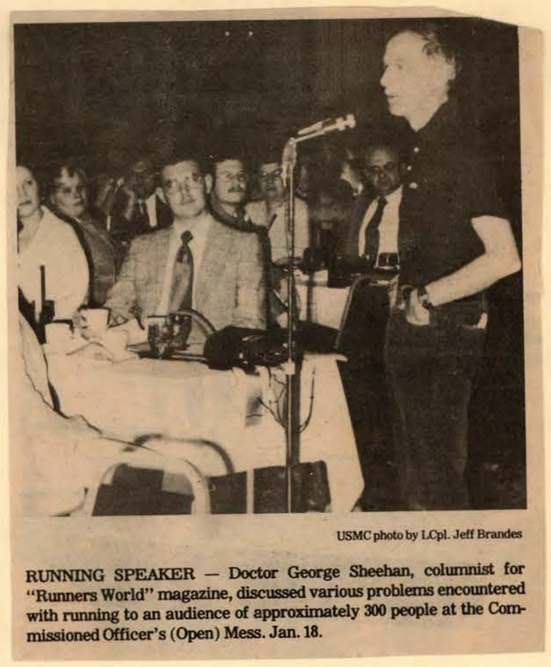

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JANUARY 1979

USMC photo by LCpl. Tracy Wrenn

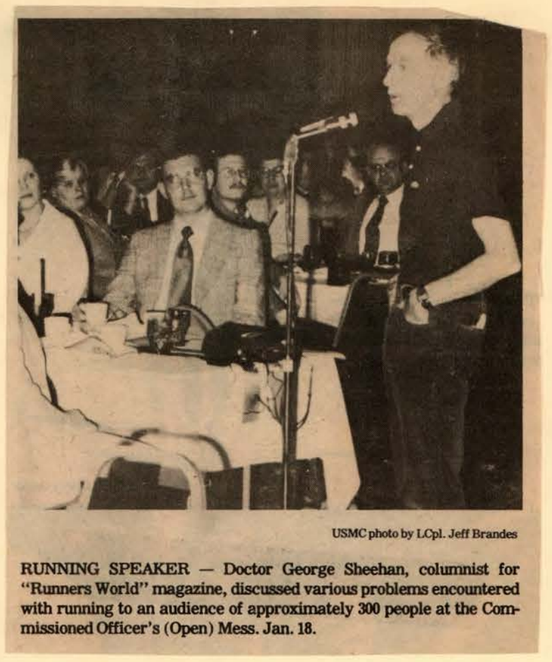
Admiral visits

Navy Rear Admiral Maxine Conder visited the Navy Regional Medical Center at Camp Lejeune recently. The Admiral inspected the hospital's facilities and met with the staff.

"CIVILIAN GUIDEPOST"
5 January 1979

NAS MILESTONE

Membership of the Camp Lejeune Chapter, National Association of Supervisors (NAS), has reached 100. Joanne Enos of the Naval Regional Medical Center is the 100th member. Pictured above, Kate Parker, Executive Vice President for the Naval Regional Medical Center "pins" Ms. Enos while Rashie Lanier (left), President; and Ronald Peedin, Vice President, look on.



USMC photo by LCpl. Jeff Brandes

RUNNING SPEAKER — Doctor George Sheehan, columnist for "Runners World" magazine, discussed various problems encountered with running to an audience of approximately 300 people at the Commissioned Officer's (Open) Mess. Jan. 18.

February 1, 1979 Globe 3

USMC photo by LCpl. Tracy E. Wren

ADMIRAL VISITS HOSPITAL — Navy Rear Admiral Maxine Conder visited the Navy Regional Medical Center Jan. 24 and 25 here to inspect the hospital's facilities and meet with the staff. As the Director of the Navy Nurse Corps she has the responsibility to visit every Naval Hospital world-wide. Her Navy career spans 28 years.

Civilian Guidepost

Compiled and Edited by

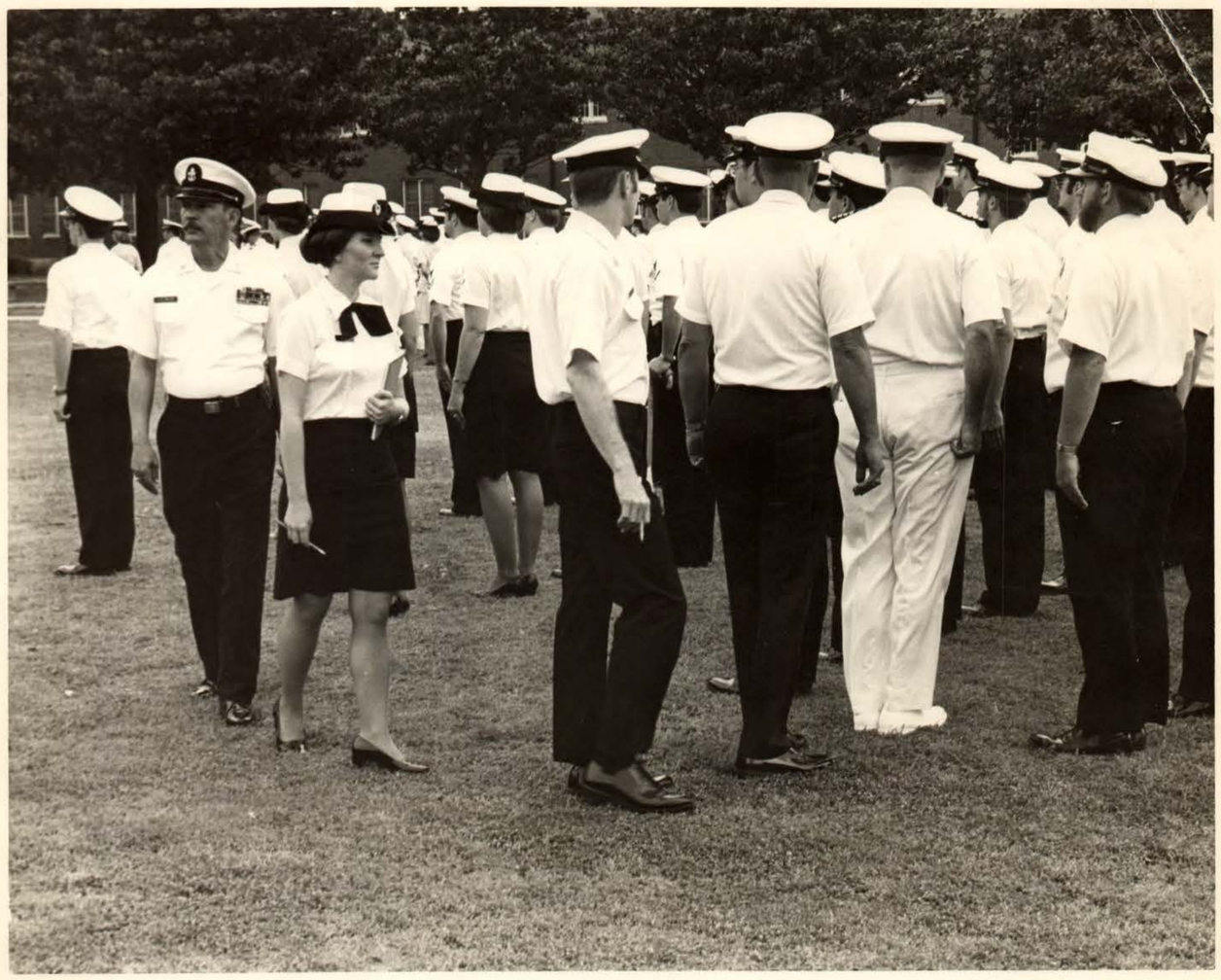
CIVILIAN PERSONNEL OFFICE, MARINE CORPS BASE, CAMP LEJEUNE, NORTH CAROLINA

Issuance of this periodical approved in accordance with Department of the Navy Publications and Printing Regulations

VOLUME 24 NO. 4 16 FEBRUARY 1979

NAVAL REGIONAL MEDICAL CENTER AWARDS

Captain James L. Hughes, Commanding Officer, Naval Regional Medical Center, recently presented Department of the Navy Federal Length of Service Awards to employees of the Center (shown left to right) as follows: Melvin L. Felton, 35 years; John G. Vavro, 35 years (Captain Hughes); Thelma M. Felton, 30 years; and Johnnie Hawkins, 30 years.



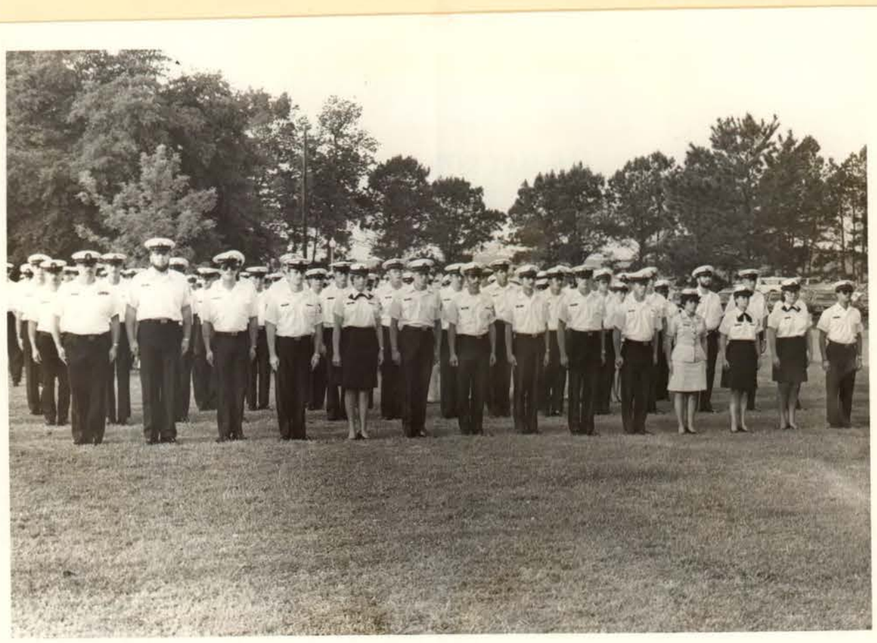
PERSONNEL INSPECTION - 27 APRIL 1979

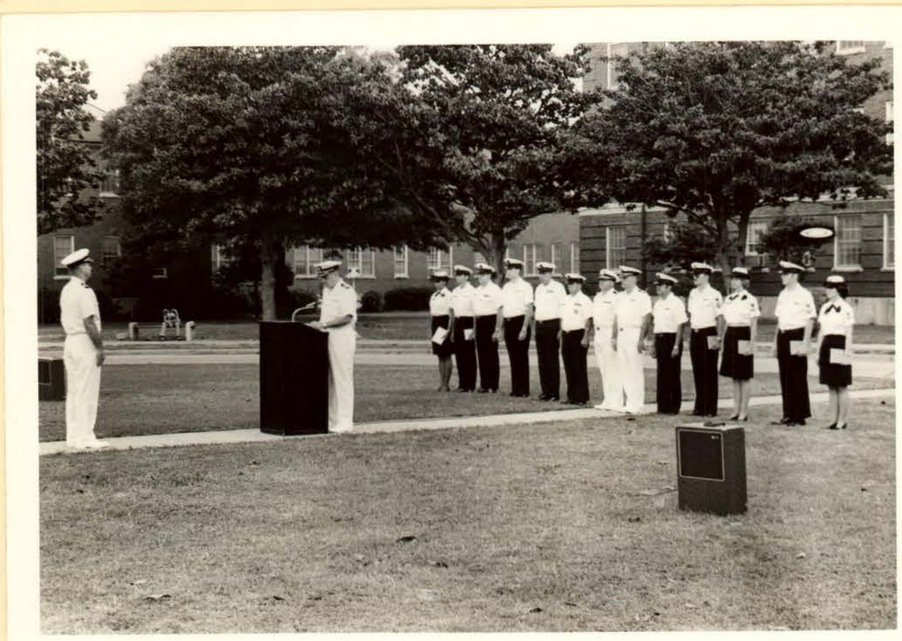
HMC JETT RETIREMENT - 1 MAY 1979

Trinidad travelers

Dr. and Mrs. James L. Hughes display their memorabilia at the International Wives' Club meeting as they tell of their travels in Trinidad and Tabago in the West Indies Islands. Mrs. Hughes is a native of Trinidad. Her ancestors sailed from Europe in search of religious and political freedoms in the New World, and her parents were born in the West Indies. They moved to Venezuela, S.A. and remained there for 30 years. Mrs. Hughes came to the United States for high school in Florida and nurses training in Baltimore where she met her husband, who is a pediatrician at the Regional Naval Medical Center, Camp Lejeune. They showed slides and talked of tropical plants, vegetation and Carnival time, which is the most important event of the year. Actually Carnival is a spirit that pervades Trinidad and Tabago all year long, as music is such an important part of the natives' lives.

PERSONNEL INSPECTION - 4 MAY 1979





4 Globe May 10, 1979

Nurses helping others for 71 years

By Sgt. Dave Smith

The most recognized heroes on the battlefield are those doing the fighting and dying for their countries. But, behind the lines, perhaps a more important task is being undertaken: the saving of lives by Navy Nurses.

On May 13, Navy nurses around the world will be celebrating the 71st birthday of the Navy Nurse Corps.

When first established in 1908, a mere twenty nurses comprised the Corps. Since then, their number has increased to over 2,600, and their skills have become increasingly diversified.

Navy nurses in the 123 military hospitals and dispensaries scattered throughout the United States and at 29 naval bases in foreign countries are trained in a variety of specialties, including anesthesiology, family and pediatric practice, operating room procedures, obstetrics and gynecology.

In 1941, the nurses received their first issue of uniforms, and the Army-Navy Nurses Act of 1947 finally established them as commissioned officers of staff rank.

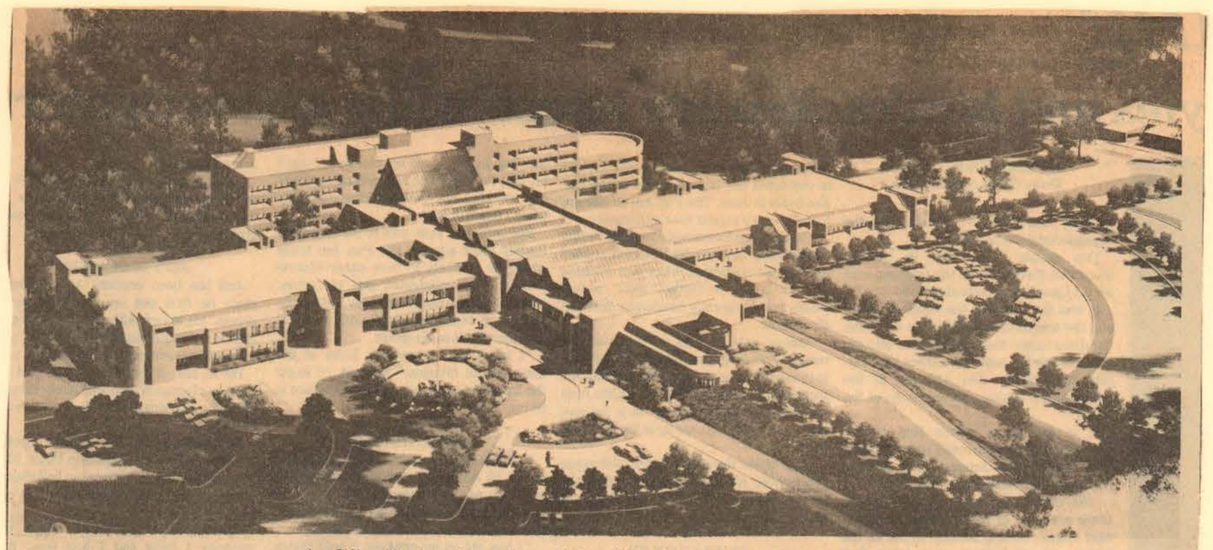
Local Navy nurses will hold a social in celebration of the birthday from 7 to 9 p.m., May 12 at the Paradise Point Commissioned Officers Mess.

USMC photo by Sgt. Dave Smith

A HAPPY PATIENT — The careful hands of Lieutenant Junior Grade Gayle Wilbur earn a smile from one of her patients, Corporal John Tomyl, Marine Wing Support Group-27, Marine Corps Air Station (H), New River.

USMC photo by Sgt. Dave Smith

A CLOSE WATCH — Ensign Pilar Garcia monitors the flow rate of an intravenous solution during a routine work day at the Naval Regional Medical Center, Camp Lejeune, N.C.



Architect's drawing of new $39 million hospital at Camp Lejeune

Facility to have 205-bed capacity

Ground broken for $39 million hospital

Groundbreaking ceremonies were conducted at Camp Lejeune on Friday morning for a new $39 million hospital.

The 425,000-square-foot building at Brewster Boulevard and Stone Street will have beds for 205 patients. Construction is to be completed by 1982.

The hospital will have office space and examination rooms for 80 physicians, five operating rooms, five labor rooms, three delivery rooms, an eight-bed intensive and coronary care unit, and aneonatal intensive care unit.

A central computer system will monitor security and energy use in the building.

The new medical complex will replace the Naval Regional Medical Center at Hadnot Point, built in 1943.

May 10, 1979 Globe 2

Ground breaking ceremony held for $50 million hospital

Groundbreaking ceremonies for a new $39 million hospital took place May 4 here.

The new facility, scheduled to be completed by 1982, will replace the present Naval Regional Medical Center at Hadnot Point, which was constructed in 1943.

The new complex will be built on a 162-acre tract located near the intersection of Stone Street and Brewster Blvd. When finished, the facility will have approximately 425,000 square feet of floor space, able to provide inpatient service to 205 people.

The ultra-modern hospital will have the capacity to afford 80 physicians enough office space to include one or two examination rooms, depending on specialty. It is also designed to allow easy access to clinic areas for out-patient users.

The surgical department will contain five modernly designed operating rooms equipped with the most advanced apparatus. The Obstetrical section will have five labor rooms and three delivery rooms.

The new complex will also contain an eight-bed Intensive and Coronary Care unit, as well as a Neonatal Intensive Care unit.

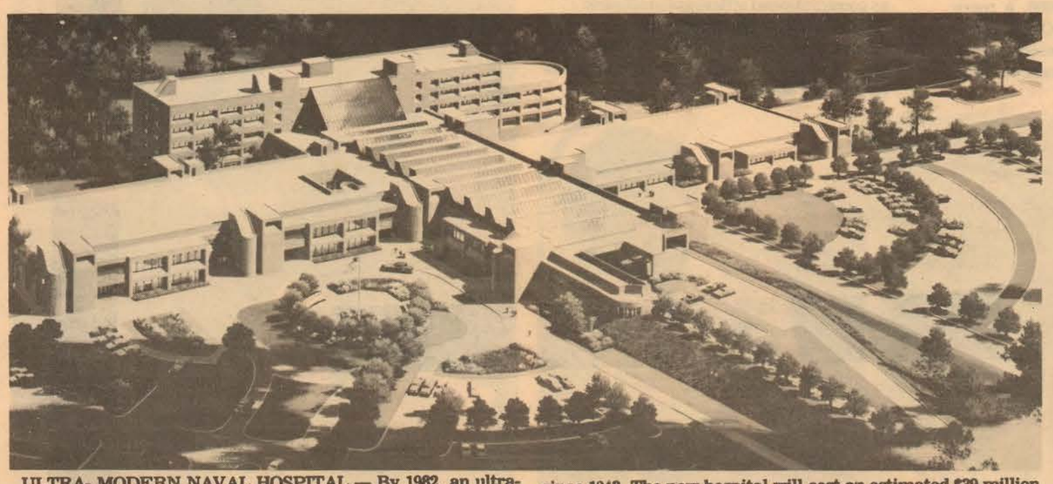
In an age of modern medicine, the facility will contain a Nuclear Medicine Service and expanded services in Laboratory and Radiology. These services combined will give the hospital the latest and fastest diagnostic capabilities.

As a sidelight, the hospital will have a central computer system that will monitor everything from security to energy use within the building. Also, the newest techniques in fire prevention and detection have been employed in the planning of the structure.

In addition to the $39 million price tag on the facility and its fixed equipment, $2.2 million of telephone equipment and other communication equipment within the hospital will be added.

The purchase of non-fixed materials such as furnishings and equipment essential to the office and examination rooms will cost another $8 million.

The complex, which will have a total cost of approximately $51 million when the doors open, is being built by a Dallas, Texas firm.



ULTRA- MODERN NAVAL HOSPITAL — By 1962, an ultra-modern Naval Regional Medical Center, as rendered by an artist, will replace the medical facility that has been in use here since 1943. The new hospital will cost an estimated $39 million to construct. (Artist's conception courtesy Naval Regional Medical Center, Camp Lejeune, N.C.)

AWARDS CEREMONY 16 MAY 1979

Civilian Guidepost

Compiled and Edited by

CIVILIAN PERSONNEL OFFICE, MARINE CORPS BASE, CAMP LEJEUNE, NORTH CAROLINA

Issuance of this periodical approved in accordance with Department of the Navy Publications and Printing Regulations

VOLUME 24 NO. 11 — 25 MAY 1979

SEMINAR HELD
FOR
HEARING HANDICAPPED EMPLOYEES

Hearing handicapped employees recently attended a personnel orientation seminar structured to serve their particular employment information needs.

The seminar was conducted by the Civilian Personnel Office staff and the Deputy Equal Employment Opportunity Officer. This was the first organized training offered for hearing handicapped employees.

Mary Lou Grant of the North Carolina Vocational Rehabilitation Office in Goldsboro did an outstanding job as interpreter for the group. Attending the seminar were (pictured left to right): Jimmy E. Miller (Ms. Grant), Debra A. Norris, and Sybil C. Layton of Base Materiel Battalion; Percy L. Pollock of Base Maintenance Department; and Earl L. Maready of the Naval Regional Medical Center.

"CIVILIAN GUIDEPOST 25 May 1979

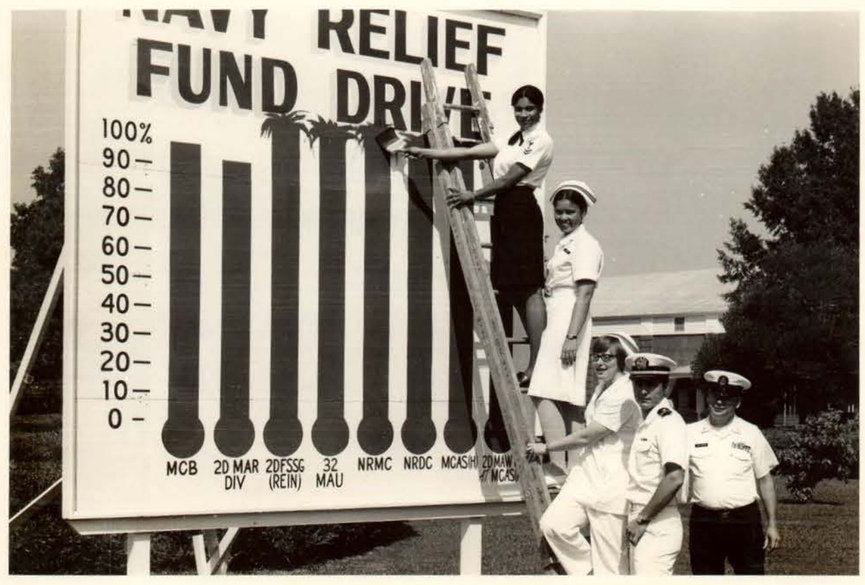
LENGTH OF SERVICE AWARDS PRESENTED

Captain James L. Hughes, Commanding Officer, Naval Regional Medical Center, recently presented 30-year Federal length of service awards to the following employees of the Center (pictured, left to right): Raymond Rhyne, James N. Sirmon, and Pearl L. Robinson.

"CAMP LEJEUNE CIVILIAN GUIDEPOST" 22 June '79

THIRTY YEARS OF SERVICE RECOGNIZED

Captain James L. Hughes, Commanding Officer, Naval Regional Medical Center, recently presented 30-year Federal length of service awards to Nancy B. Anderson (center) and Mabel H. Fryar.



1979 NAUREGMEDCEN, CLNC
NAVY RELIEF FUND DRIVE

204 years supporting Corps

Navy celebrates birthday

By Cpl. Ann Prezell

When General George Washington took command of the American forces in 1775, he realized the need for coastal protection. He converted several small schooners into warships and enlisted Massachusetts young men into "Washington's Fleet," a shadow of what is today America's protectors at sea...the United States Navy.

The beginning year was 1775, the Revolutionary War was in progress, and on October 13 the Continental Congress made it official. They authorized the acquisition and construction of ships for a Navy.

Saturday marks the 204th anniversary of that day.

For Navy enlisted personnel here, the birthday celebration will be culminated in a cake-cutting ceremony and ball on October 12, at Geottge Memorial Field House.

Similarly, on October 13, Navy officers can enjoy a cake-cutting ceremony and ball at the Officer's Club, Marine Corps Air Station (H) New River.

For the more than 1,700 sailors assigned here, October 13 is a significant day. It is a day that Marines should hold in high regard as well, for the Navy is the vital other half of the unequaled Navy-Marine team.

In his birthday message to the Navy, Second Marine Division Commander Major General David M. Twomey reminds us that, "Marines and sailors have lived, fought and died together in every major conflict from the inception of the republic. The Navy team has served us well in war as well as peace time."

Marines can proudly boast of their past and present heroes. But serving beside them have been sailors, and they too have their heroes. Names like John Paul Jones, Commodore Matthew Perry, Admiral David Farragut, John F. Kennedy, Admiral Chester Nimitz and Neil Armstrong are just a few in a long list.

Any Marine war veteran will testify that in a combat situation, there is no one whose presence is more appreciated or comforting than that of the Navy corpsman. He commits himself to service on the battlefield and has saved a countless number of Marine lives.

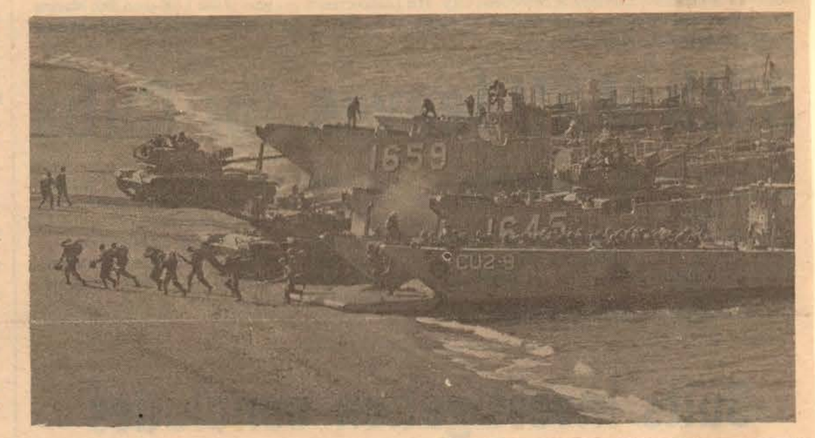
In World War II, for example, of every 100 men who were wounded, 97 were recovered. On Iwo Jima, the percentage of casualties among corpsmen was greater than among the Marines.

In peace time, their contributions and support are also invaluable. Brigadier General John Phillips, commanding general, 2d Force Service Support Group, singles out the men of the Navy Regional Medical Center for their professional medical care for both military personnel and their families.

"Your contribution," he says, "not only enhances our readiness to deploy, but contributes significantly to the morale and welfare of our military community."

The Navy provides support to the Marine Corps at the dispensaries, the naval hospital, and the dental center. It also provides Navy members of Air Naval Gunfire Liaison Company, and boat crews who patrol the Inlandcoastal Waterway.

Some sailors here admit feeling out of place in this predominately Marine community. This special weekend is a good opportunity for Marines to make their naval counterparts feel "at home" and let them know that we know they are a necessary and welcome component of our community.



CHIEF OF NAVAL OPERATIONS

As we celebrate Navy Birthday 1979 on Oct. 13, we again have an opportunity to reflect upon the contributions and achievements of the men and women of the United States Navy.

In recent years, we have been retrospective in our Navy Birthday observances, looking back to pay homage to our history, traditions and heritage. While this remembrance is entirely appropriate, I take personal pride and satisfaction, as I'm sure you do, in my associations with today's Navy people—people who work long hours under extremely demanding circumstances at sea and ashore.

Each of you today continues to demonstrate a commitment and a devotion to duty which has made our Navy the strongest and finest in the world—qualities which you have inherited from your predecessors who served selflessly in times of peace and war. And, each of you is making your own special contribution today—contributions upon which the Navy will build in the future.

Our 204th anniversary celebration would be incomplete, however, if we failed to recognize the many other members of our Navy "family"—our wives, husbands and children, our civilian Navy employees, our Reservists and retirees. Each of these people has shared in our sacrifices and our successes, giving the support and encouragement which enables us to do our jobs well.

I offer to each member of the Navy family my appreciation for your efforts to help preserve peace and freedom throughout the world, and I send my best wishes as we celebrate Navy Birthday 1979.

T. B. HAYWARD
Admiral, U.S. Navy

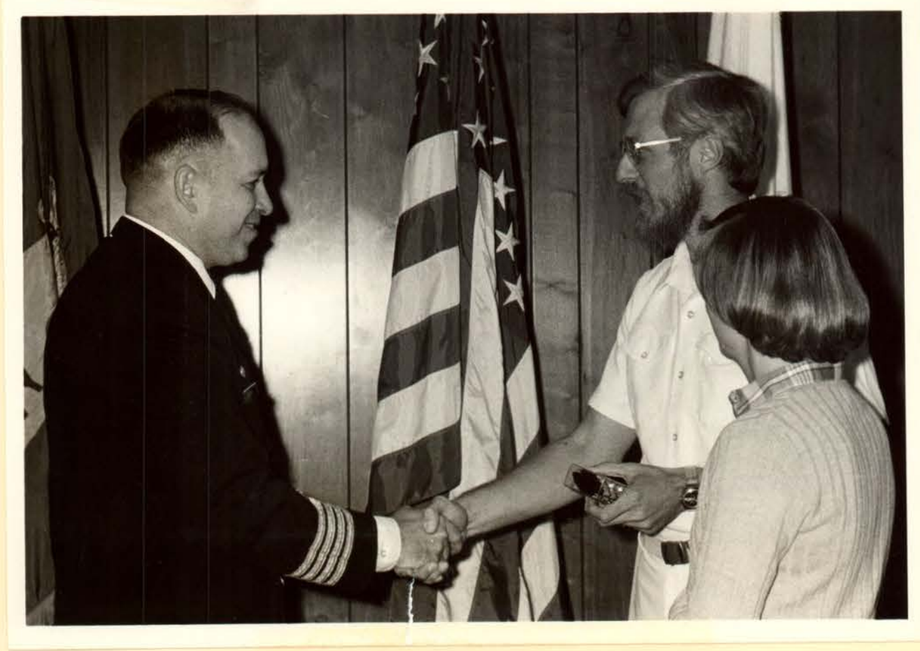
"Some of the finest Marines I've ever met have been the Navy corpsmen that have supported me and platoons in rifle companies and battalions."

MajGen. D. M. Twomey, CG, 2nd Marine Division

FIRST NAVY BABY OF 1979 - 17 OCT 1979

LT SEIBLE FROCKED TO LCDR
29 NOVEMBER 1979

ENS GILLSON FROCKED TO LTJG
5 DECEMBER 1979



LT BURNETTE, J. P. FROCKED AS LCDR
5 DECEMBER 1979

LT PETER STELMACH FROCKED AS LCDR
5 DECEMBER 1979

PATRICIA BECKWITH - LENGTH OF SERVICE AWARD - 16 MARCH 1982

HMCM POWELL, COMMAND MASTER CHIEF, NRMC AND SERGEANT MAJOR IRRERA, MARINE CORPS BASE SERGEANT MAJOR AT USO LUNCHEON, JACKSONVILLE, NC 18 APRIL 1981

MRS BARROW, WIFE OF COMMANDANT OF THE MARINE CORPS CUTS RIBBON AT NURSERY FOR CHILDREN OF AMERICAN RED CROSS VOLUNTEERS - 6 DEC 79

J. W. ENGLISH, LCDR, MSC, USN
RETIREMENT

LCDR MITCHELL FROCKED TO CDR
5 DECEMBER 1979

LT WRIGHT AUGMENTATION - 16 NOV 1979

HM2 REJAN REENLISTMENT - 27 APRIL 79

LT ROBERT YOUNG FROCKED AS LCDR
6 DECEMBER 1979

LT KNEELAND FROCKED AS LCDR
5 DECEMBER 1979

HMCM W. P. COLVIN IS PRESENTED
LETTER OF APPRECIATION

January 10, 1980 Globe 3

ONSLOW'S FIRST — Valerie Bludsworth gave birth to the first baby of 1980, a boy named Stephen by the parents, at Naval Regional Medical Center, Jan. 1 at 5:21 a.m. Valerie is the wife of Private First Class Bradley Bludsworth, 5th Battalion, Tenth Marine Regiment, 2nd Marine Division. (USMC photo by Sgt. Rick Lynch)

MR. WAYNE EVERETT (PUBLIC WORKS)
RETIREMENT - 11 JANUARY 1980

Lejeune Health Fair Helps Reduce Load

CAMP LEJEUNE, N.C. — Medical personnel at the Naval Regional Medical Center here have come up with a health education program they hope will control or reduce the demand on their facility.

Through the NRMC's "Health Fair," patients were provided information on upper respiratory and gynecological ailments, venereal disease, family planning, colds and flu.

A van, provided by the Navy Recruiting Command, was staffed by medical personnel and converted to house audio-visual displays that helped the medical team get out as much health care information as possible.

The aim of the project, NRMC officials said, was to educate people so that they would be better equipped to deal with a variety of medical problems at home before having them make inconvenient, time consuming or expensive trips to see a doctor at the medical center.

The majority of those who took part in the project felt that the Health Fair addressed pertinent problem areas. Many also felt they could solve their medical problems at home.

They suggested that future Health Fairs deal with problems such as teenage pregnancy, job-related stress, thyroid problems, knee and heel injuries, headaches, drug abuse, child abuse, breast cancer and safe, non-prescription medication.

The health education program was prompted in part by high medical costs and the shortages of physicians and other health care people at the medical center.

"Navy Times" Feb. 4, 1980

24 MAY 1979 - AWARDS CEREMONY
J. D. MILLER

Hospital nears completion

By GySgt. M.J. Branski

Marines and their families still around Camp Lejeune in 1982 will be the benefactors of a new $39 million hospital already under construction. It will replace the 37-year-old Navy Regional Medical Center which was built in 1943. Another $11 million will be spent to outfit and furnish the interior of the hospital.

"The new facility is being built by the Cardinal Contracting Company of Columbia, S.C., and is scheduled for completion in late 1982," said Lieutenant Commander H.E. Phillips, Construction Works Officer here.

The new hospital complex is being built on a 162-acre tract of land located near the intersection of Brewster Boulevard and Stone Street. When finished, the facility will have approximately 425,000 square feet of floor space, and be able to provide inpatient service for 205 people.

The ultra-modern hospital will also have office space for 80 physicians to include on or two examination rooms per physician, depending on specialty. Easy access to clinic areas for outpatient users is being built in.

Five modernly designed operating rooms, with the most advanced equipment will make up the Surgical Unit. The Obstetrics Unit will have five labor rooms and three delivery rooms.

An eight-bed Intensive Care and Coronary Unit, as well as a Neonatal Intensive Care Unit will also be included.

In an age of modern medicine, the facility will contain a nuclear medicine service and with expanded services in laboratory and radiology. These combined services will give the hospital the latest and fastest diagnostic capabilities available.

RIGHT ON SCHEDULE — Construction crews continue work on the medical center that is slated to begin operations in 1982.

(USMC photo by LCpl Brandes)

Globe
10 April 1980

Servicemen show their support

By DAVID SHELLEY
Daily News Staff

Carrying a "We Ran Against Iran" flag, Navy Petty Officer 1st Class Douglas Heidel ran the first three-mile leg on a 200-mile "Freedom Run" from Camp Lejeune to Portsmouth, Va., Friday morning.

Heidel and other organizers for the run said it is intended to rally support for the United States and for the American hostages in Iran.

Eleven sailors and one Marine are taking part in the run, which began in front of the Naval Regional Medical Center and is scheduled to end in Portsmouth on Saturday afternoon.

Nine men and two women are running three-mile relays in an attempt to get to Portsmouth in 30 hours.

Heidel said the runners would be spurred on by thoughts of the difficulties endured by the hostages in Iran.

"We're running 200 miles in 30 hours," he said. "If we feel like giving up, we'll ask ourselves, 'I'm going through this, but what are (the hostages) going through?'"

Heidel said he hopes the run will encourage Americans to write their congressmen about the Iranian crisis.

The runners were given a sendoff at Camp Lejeune by a group of veterans and Navy Capt. James L. Hughes, the commanding officer of the medical center.

The first exchange of a "freedom baton" between the runners came after Heidel completed the first three miles of the run. The sailor turned the baton over to Petty Officer 3rd Class Walter Roland.

The runners made their way north along U.S. 17, passing through New Bern, Washington and Williamston on their way to Portsmouth.

Heidel, Roland and Lt. James Garrett began organizing the run in December. The run was to have been held in January, but the event was met with a series of delays.

"We got the idea from similar runs for freedom for (American prisoners of war) during the Vietnam era," Heidel said.

Staff photos by Randy Davey

Heidel takes first leg on 200-mile "Freedom Run"

IRIS FABY RETIREMENT -
7 MARCH 1980 - CIVILIAN FISCAL
SUPPLY SUPERVISOR

GROUND BREAKING CEREMONY

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY

NAVAL REGIONAL MEDICAL CENTER
CAMP LEJEUNE, NORTH CAROLINA
4 MAY 1979

"CAMP LEJEUNE GLOBE" 8 May 1980

On Tuesday, Nurse Corps officers will pause a moment in the steady beat of passing time to re-examine the roots of their past and to rededicate themselves to the principles and ideas that have kept the spirit of the Corps alive.

Happy 77th Birthday– U.S. Navy Nurse Corps –once again, the candles are lit!

TENDER CARE — Lieutenant (Junior Grade) Lucinda Sullivan of the Navy Nurse corps holds a dependent child for a routine checkup. The Nurse Corps celebrated their 72nd anniversary Tuesday and have provided their competent skills in a vast number of different tasks. Eighty-three nurses here serve the demanding needs of Marines, Sailors and their dependents. (Photo courtesy of HN. J.L. Whitlaker)

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GROUND BREAKING CEREMONY

MUSIC BY - SECOND MARINE DIVISION BAND

INVOCATION
Lieutenant Commander P. D. Robinson, CHC, USN

INTRODUCTION OF COMMANDING OFFICER
Commander J. E. DeWitt, MSC, USN
Director of Administrative Services

WELCOMING REMARKS AND INTRODUCTION OF DISTINGUISHED GUESTS
Captain J. L. Hughes, MC, USN
Commanding Officer

GROUND BREAKING ADDRESS
Brigadier General D. B. Barker, USMC
Commanding General Marine Corps Base
Camp Lejeune

GROUND BREAKING

BENEDICTION
Lieutenant Commander P. D. Robinson, CHC, USN

Servicemen show their support

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Servicemen show their support

By DAVID SHELLEY
Daily News Staff

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Heidel and other organizers for the run said it is intended to rally support for the United States and for the American hostages in Iran.

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The runners were given a sendoff at Camp Lejeune by a group of veterans and Navy Capt. James L. Hughes, the commanding officer of the medical center.

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The runners made their way north along U.S. 17, passing through New Bern, Washington and Williamston on their way to Portsmouth.

Heidel, Roland and Lt. James Garrett began organizing the run in December. The run was to have been held in January, but the event was met with a series of delays.

"We got the idea from similar runs for freedom for (American prisoners of war) during the Vietnam era," Heidel said.

Staff photos by Randy Davey

Heidel takes first leg on 200-mile "Freedom Run"

"CAMP LEJEUNE GLOBE" 8 May 1980

On Tuesday, Nurse Corps officers will pause a moment in the steady beat of passing time to re-examine the roots of their past and to rededicate themselves to the principles and ideas that have kept the spirit of the Corps alive.

Happy 77th Birthday-- U.S. Navy Nurse Corps --once again, the candles are lit!

TENDER CARE — Lieutenant (Junior Grade) Lucinda Sullivan of the Navy Nurse corps holds a dependent child for a routine checkup. The Nurse Corps celebrated their 72nd anniversary Tuesday and have provided their competent skills in a vast number of different tasks. Eighty-three nurses here serve the demanding needs of Marines, Sailors and their dependents. (Photo courtesy of HN. J.L. Whittaker)

24 MAY 1979 - AWARDS CEREMONY
J. D. MILLER

Hospital nears completion

By GySgt. M.J. Branski

Marines and their families still around Camp Lejeune in 1982 will be the benefactors of a new $39 million hospital already under construction. It will replace the 37-year-old Navy Regional Medical Center which was built in 1943. Another $11 million will be spent to outfit and furnish the interior of the hospital.

"The new facility is being built by the Cardinal Contracting Company of Columbia, S.C., and is scheduled for completion in late 1982," said Lieutenant Commander H.E. Phillips, Construction Works Officer here.

The new hospital complex is being built on a 162-acre tract of land located near the intersection of Brewster Boulevard and Stone Street. When finished, the facility will have approximately 425,000 square feet of floor space, and be able to provide inpatient service for 205 people.

The ultra-modern hospital will also have office space for 80 physicians to include on or two examination rooms per physician, depending on specialty. Easy access to clinic areas for outpatient users

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The four-story medical facility to be constructed at this ground breaking site will replace in its entirety the 20 building contonement style hospital, constructed at Hadnot Point in 1943.

The replacement medical facility will contain approximately 425,000 square feet of floor space in the main hospital building which includes power plant and warehouse. The hospital, which provides space for 205 patients plus extensive general and specialty care outpatient clinics, is of ultra-modern design and uniquely color coordinated to encourage a warm and pleasant environment. The hospital will occupy a beautiful waterfront site on Northeast Creek making maximum use of its natural wooded setting. Inpatient spaces are designed in private, semi-private, and four bed units to permit mixing of patient categories on each nursing unit by medical specialty, thereby maximizing utilization of inpatient beds at all times.

The design of the hospital incorporates the most modern concepts in modern hospital operations including a centralized material management center which will provide daily deliveries of all medical-surgical supplies and linen required to operate the hospital. The building also has a central computer that will monitor and control all critical building systems from medical gases to the utilization of energy within the hospital complex. In addition, the computer will manage the hospital's preventative maintenance program for both plant and technical-medical equipment.

For the safety of our patients, staff and visitors, the latest concepts in fire protection systems will be provided. Additionally, closed circuit television surveillance equipment will monitor all sensitive areas of the complex. In the event of a power failure, an emergency power distribution system will be on standby to provide electrical service to all critical systems and equipment.

As we begin a new phase in the history of the Naval Regional Medical Center, we look optimistically to the future and the improvement in the health services available to our Navy- Marine Corps family that this facility will make possible.

Servicemen show their support

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Daily News Staff

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"CIVILIAN GUIDEPOST" 6 June 1980

LENGTH OF SERVICE AWARDS

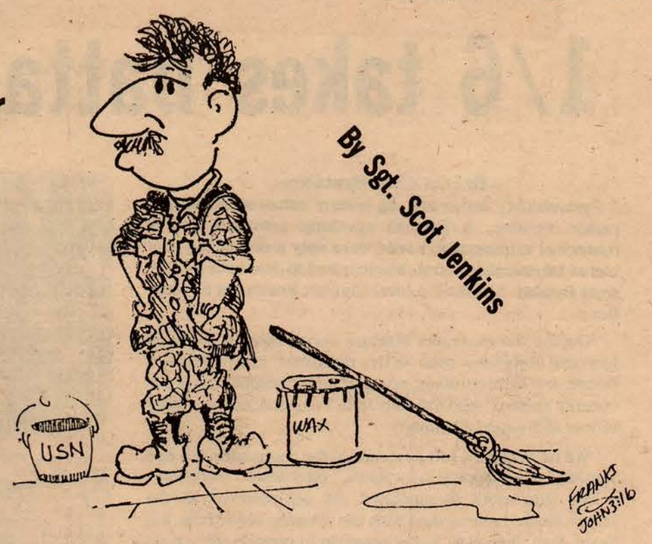
Captain James L. Hughes, Commanding Officer, Naval Regional Medical Center, recently presented 35 year length of service awards to James E. Hill and Jethro Craven, top picture, left to right. Captain Hughes also presented 30 year awards to Rossie L. Mitchell and Leeotis Roby, bottom, left to right.

FUND RUN — The entrants in the Navy Relief 10,000 Meter Run at the Navy Regional Medical Center last Saturday raised more than $200 for the Navy Relief Fund Drive. LCpl. Gary Lewis led all runners to the finish in a time of 31:59. The monies collected were added to the $188,000 already contributed, with only one day remaining in the 1980 fund-drive. (USMC photo by Cpl. Stephan M. Rogers)

Situation drawings part of career

Corpsman injects humor

By Sgt. Scot Jenkins



It might be hard to believe, but giving shots and taking temperatures can be boring. One Navy Corpsman here, however, has found a way of making his job interesting, regardless of the situation.

Hospitalman First Class Jerry Franks loves to draw.

"I draw what I call situation drawings," said Franks. "I try to capture the real feeling of the situation I am drawing."

The 30-year-old Columbus, Miss., native joined the U.S. Army during the height of the Vietnam conflict in 1969.

"I went to boot camp at Fort Bragg, N.C., and while I was there I began to draw," said Franks. "I drew quick illustrations of the most memorable events in boot camp for different guys."

While Franks was in Vietnam he served with a medical supply unit which shared its facilities with a Navy medical unit.

"At the medical unit I had my first contact with Navy corpsmen," said Franks. "I never thought of them as Navy corpsmen, but as Marine Corps' corpsmen. In fact, when I first met a Navy corpsman I thought he was a Marine."

Even in Vietnam, Franks found time and the supplies to draw.

"While I was in Vietnam, I drew cartoons on helmets," said Franks. "I drew whatever the guys wanted. One guy, nicknamed 'Stretch,' had me make a drawing of him chained from his ankles with his body stretched all across the helmet."

Franks' first painting in Vietnam was of a "Freedom Bird" (aircraft returning Vietnam veterans to the U.S.).

"I did the painting because the place where I was was very depressing. I borrowed supplies from the Army and Navy and wherever else I could get them," said Franks. "In fact, I even used my hair to make paintbrushes."

The basic skills Franks learned in a high school art class paid off.

"Because of my art class I was able to learn almost anything can be used for drawing," said Franks.

One of Franks' most interesting assignments during his 12 years with the military was his two and half years with 2nd Reconnaissance Battalion, 2nd Marine Division.

"I had to meet the physical requirements, including long runs and swims at night. I didn't mind all the physical stress," said the blond-haired Corpsman.

Even with Recon, Franks kept up his artwork, specializing in the Recon emblem of a skull over crossed bones.

Art is strictly a hobby for me," said Franks. "I have found most people don't really know what they look like. A photograph can capture the event but a drawing can capture the feelings and meanings of an event."

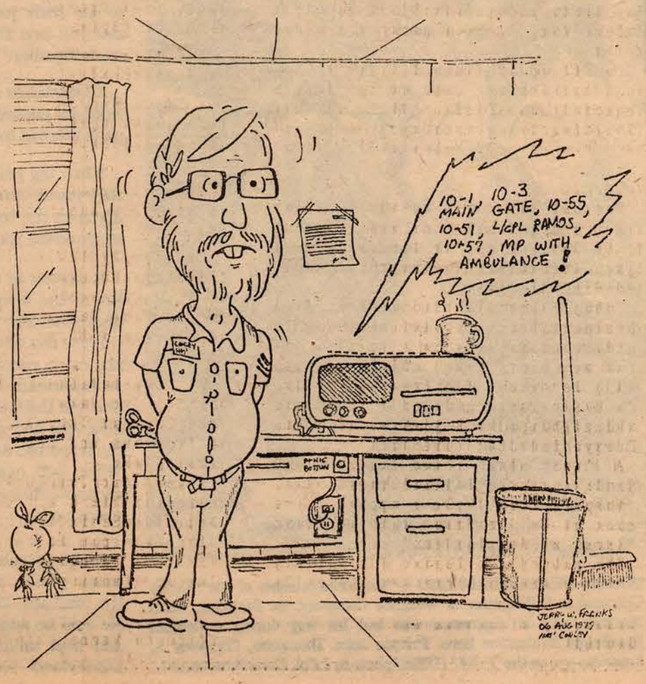
Franks has always enjoyed working with Marines. In fact, out of his eight years in the Navy, seven have been spent with the Marine Corps.

"Marines are good people and I don't mind going in the field with them. They take care of their Corpsmen, and it is great to know that the men support you."

Franks' job at Camp Lejeune is dispatching, maintaining and resupplying all the ambulances in the Camp Lejeune area.

"I have found that drawings lighten the tensions of people. We all have our little quirks and it helps if we can laugh at them. So I just help people laugh at their own quirks with my cartoons," Franks said.

ETCHING FOR FUN — Hospitalman First Class Jerry Franks etches a nature scene outside Building 15 on base. Franks, a 12-year veteran, spends a lot of his spare time drawing what he terms "situational drawings." (USMC photo by Sgt. Scot G. Jenkins)



FAMILY AFFAIRS

Pet protection possible

Rabies spreading up east coast

By Cpl. L.S. Lewis

An epidemic of rabies is spreading up the east coast, according to Doctor John Freeman, North Carolina's Public Health Veterinarian in Raleigh. Pet owners at Camp Lejeune should have their domestic animals vaccinated as soon as possible.

Service people living in base quarters here are required to have their pets inoculated.

Pet owners can prevent their animals from contracting rabies by getting them inoculated with a single injection to the animal's hind quarters. Owners neglecting this simple procedure increase the possibility of their pets being infected with the fatal disease. All warm-blooded mammals are susceptible to rabies.

Marines can get their dogs and cats vaccinated at the base Animal clinic (Bldg. PT-37) here, for a nominal fee.

"Because of the workload, we operate by appointments only for the vaccination clinic," stated Air Force Captain Jon M. Eckstein, officer-in-charge.

"Once an animal has rabies, we can't do anything for it," stressed Eckstein. "The animal has to be destroyed or it will suffer a painful death in five or six days."

"Compared to some of the other hot spots, North Carolina has a fairly low number of victims," commented Gunnery Sergeant Donald L. Beal, noncommissioned officer-in-charge of the clinic. "But this is a direct result of people getting their animals vaccinated."

According to authorities, rabies cases in the United States have increased from approximately 2,000 per year for the last three years, to approximately 5,000 in 1979.

Service members and their families can call the Base Animal Clinic for appointments Mondays from 8:30 a.m. to 3 p.m., for their cats and dogs at base extension 1009.

BOTTOMS UP — 'Tig-Tig', an 11 week old cock-a-poo is one of the fortunate dogs and cats brought by their owners to the base Animal Clinic to be vaccinated against rabies by Captain Jon M. Eckstein, veterinarian. His owner, Corporal Kathy E. Brett of Headquarters Battalion, Marine Corps Base, has prevented him from becoming a victim of the rabies epidemic spreading up the east coast. (USMC photo by Cpl. L.S. Lewis)

LTJG C. K. BIRD, MSC, USN -
PROMOTION TO LIEUTENANT - 15 JUL 80

"CAMP LEJEUNE GLOBE" 31 July '80

FAMILY AFFAIRS

A pet-icular problem solved

By Cpl. L.S. Lewis

The cost to owners for pet care is often so costly that consequently, skin diseases and internal ailments go undetected or untreated.

One of the many benefits offered service members and their families here is a Base Animal Clinic, where their pets can receive veterinarian care at a nominal fee.

"Preventing rabies and other communicable diseases is our main concern," explained Air Force Captain Jon M. Eckstein, the clinic's officer-in-charge. "We try to stop these problems before they reach epidemic proportions."

"In this area, we have a problem with Round, Hook, and Heart Worms," remarked Gunnery Sergeant Donald L. Beal, veterinarian technician and noncommissioned officer-in-charge. "Mainly, because people don't know about us when they can't afford the civilian veterinarian's fee, they let their animals go untreated.

Round and Hook worms can be detected with a simple test taking approximately 20 minutes.

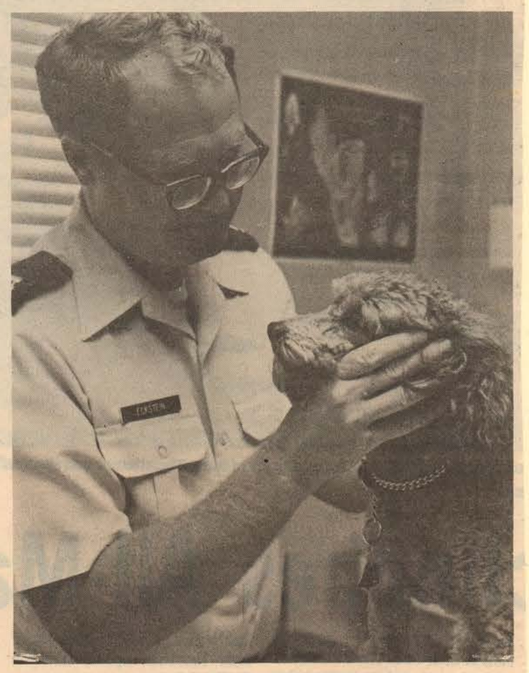
"Owners are contacted within 24 hours after the examination with the results," stated Beal.

The third major internal parasite common to this area is Heart Worms. Since they travel through the blood stream, a small blood sample is required.

"To guard against all internal parasites, pets should be examined semi-annually," stressed Beal. "The old wives tale of 'all dogs have worms' is false. But they can get them again and again."

Besides these examinations, the clinic can treat humans with diseases transmitted from animals, such as rabies. They also sell medication for all internal parasites except Heart Worms, which requires arsenic and has to be treated off base.

The clinic only treats cats and dogs by appointments. Pet owners should call for appointments on Monday from 8:30 a.m. to 3 p.m. at base extension 1009.



OPEN WIDE — Checking dogs and cats for skin diseases is one of the many services Air Force Captain Jon M. Eckstein, base clinic veterinarian, offers to pet owners stationed here. (USMC Photo by Cpl. L.S. Lewis)

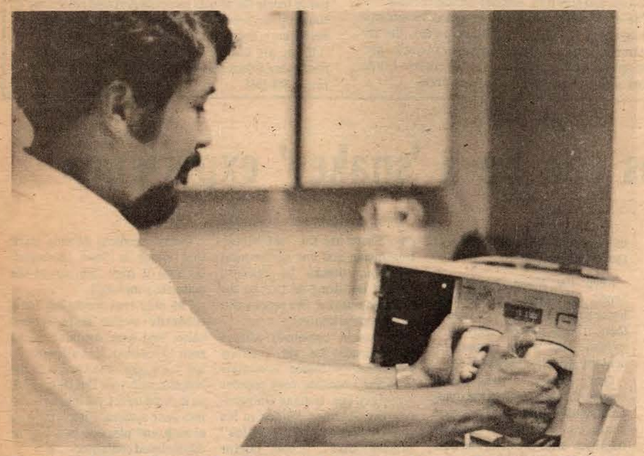
LT SUE STELMACH FROCKED AS LCDR
5 DECEMBER 1979

LT KENNETH KOPP FROCKED AS LCDR
5 DECEMBER 1979

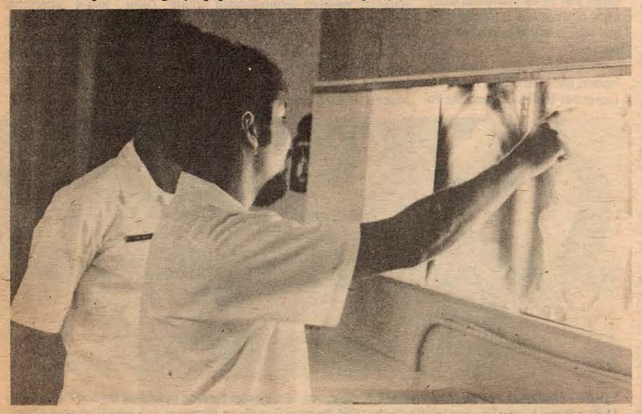
Emergency medical teams stand between life & death

Story and photos by Cpl. L.S. Lewis

EYE CHECK — During a simulated examination in an ambulance, Hospitalman Third Class James E. Miles' eyes are checked for proper dilation with a flashlight by Hospitalman Second Class David M. Blanding. The two corpsmen are demonstrating one of the many steps the base emergency medical teams take when examining patients.



EKG — Checking the charge and discharge of the defibrillator monitor, Hospitalman Second Class Marco W. Clark completes his nightly equipment check at the emergency room.



CHECKING X-RAY — Senior Corpsman of the emergency room, HM-2 Marco W. Clark, discusses x-rays of a patient to a fellow corpsman. (USMC Photo by Cpl. L.S. Lewis)

A summer rain storm rages as dime-size rain drops pound the concrete along North Carolina Highway 24. An orange and white ambulance slides to a stop as Hospitalman Second Class David M. Blanding, with medical kit in hand, jumps out.

Within moments he's directed to the driver of the mangled car, hit by a large truck. After a quick assessment, Blanding reports vital signs to his partner, Marine Driver Lance Corporal Kevin P. Vaughn.

After Vaughn radios the information ahead, the victim is placed in the waiting ambulance. Then the vehicle heads toward the hospital as its red flashing lights reflect off the steady downpour.

Twenty-four hours a day, teams of Marines and Corpsmen are on duty, ready to handle life or death situations. These professionally trained men and women make up the emergency medical teams manning the base ambulance service.

"Our purpose is to answer all emergency calls reported by the base military police (PMO), the Fire Department and occasionally civilians," explained Hospitalman Third Class James E. Miles. "We handle problems both on and off base."

On base, most of the calls involve assaults, drugs and alcohol abuse. Off base, the team handles everything from heart attack to emergency child births.

"Our 'street' medicine is very different from the care offered at hospitals," stressed Hospitalman Ed L. McCombs. "We improvise with what equipment we have, often in uncontrolled environments. Our main concern is to stabilize the patient until we can safely transport him to the nearest hospital."

There are some misconceptions about the purpose of the team.

"People sometimes seem to think we are a sick bay on wheels," declared McComb. Nothing is so frustrating and dangerous as to be on an unnecessary call when there is a real emergency some place else and we are tied up."

Navy attendants on the team are from Company B, 2nd Medical Battalion, 2nd Force Service Support Group, while the Marine drivers are supplied by Motor Transport Company, Support Battalion, Marine Corps Base.

"Unlike many bases, we have been combining corpsmen attendants and Marine drivers into a medical team since the mid 1960s," remarked Master Chief M.F. Powell, Director of Dispensery Services here. "By using both sources, we have shown once more the effectiveness of the Navy-Marine Team."

There are four separate emergency stations on base; Camp Geiger, Courthouse Bay, Marine Corps Air Station (H), New River and the Branch Clinic (Bldg. 15) at Hadnot Point. In summertime, an emergency station is also at Onslow Beach.

"We usually have two teams of two men each and a duty dispatcher at each station," commented Miles. "One is the primary, while the second team acts as a back-up.

To be on the emergency team, both attendants and drivers must be graduates of the Emergency Medical Technician (EMT) course which is a college-accredited program co-sponsored by the Naval Regional Medical Center (NRMC) here and Coastal Carolina Community College. The classes are held at the NRMC and are the equivalent of 141 college hours.

"During the course we're taught the basics of emergency care," explained Blanding "Both drivers and corpsmen are required to have the course in order to answer calls off base in North Carolina."

At the end of the course the Marines are just as informed on emergency medicine as the trained corpsmen.

"I let the corpsman of the team take the lead," reported Vaughn. "But if need be, I can assist and take over if the situation calls for it."

Once through the EMT course, the new technicians go through a period of on-the-job-training. They ride around with the regular teams and get the feel of the job, then they begin to stand duty.

"When I first started out I was scared to death," remarked Vaughn. "There are certain steps to follow and besides we know we're professionals.

Before the ambulance ever leaves the station they get the name of the caller, a description of the problem and the location of the emergency. Prior to starting the engine, the driver pin points exactly where the emergency site is on several large maps in the dispatch room.

"People are used to seeing ambulances rushing to the scene with sirens blaring," stated Vaughn. "We are not allowed to go over the speed limit. Once we have the patient, we proceed to a hospital at a safe speed. Sometimes we are only going five miles per hour."

All military patients are taken to NRMC on base, whereas the civilian patients are transported to Onslow Memorial Hospital. If the situation is critical and NRMC is closer, civilians can be taken to NRMC to be stabilized.

"We have a 13-mile radius we are responsible for along with civilian medical teams," said Miles. "Some nights the calls are back to back and on others hours will pass between calls."

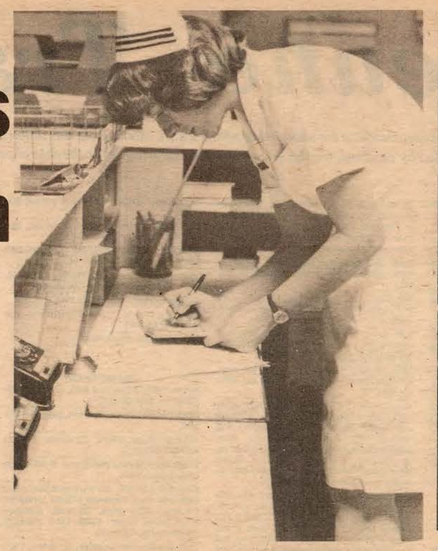
During the slack periods, the teams pass time the best they can. At night, they take turns sleeping, making sure they are rested and alert at all times.

"When we have an entire night with no calls, the next morning I feel depressed," stated Vaughn, "I'm here to help people, and there's no feeling like saving someone's life."

From the moment they pick a patient up in the ambulance to handing him over to a nurse or doctor at the hospital they're responsible for that patient. Trying to be uninvolved emotionally isn't always easy.

"Even though you try to be unmoved by the situation, you are involved," commented McCombs. "But you jump in and do the best possible job you can."

The reward for all their efforts is the knowledge they were the ones to save a life or keep a patient going until the medical specialists at the hospitals were able to help.



KEEPING THE RECORD STRAIGHT — Logging in admissions is one of the many duties of Lieutenant (junior grade) Lucinda A. Sullivan as duty staff nurse in the NRMC emergency room.

10-4 — Radioing ahead a patient's vital signs is one of the many responsibilities of PFC Teresa A. Briggs, a Marine driver from the base emergency medical team. Briggs is one of the five woman Marine drivers supplied to the emergency team.

ER: important 24-hour operation

By Cpl. L.S. Lewis

Stainless steel equipment, sterile gauze, and well oiled gurneys (portable tables) await patients being rushed to the Emergency Room (ER) at the Naval Regional Medical Center here.

Around the clock, nurses, doctors and corpsmen are constantly alert, making it possible to save lives of patients being rushed to the emergency room.

"The patients are transported to us by both military and civilian ambulances," said Lieutenant (junior grade) Lucinda A. Sullivan, ER staff nurse. "Then we also have patients brought in by friends and family."

Private parties bringing in patients sometimes create a problem for the ER staff.

"The ER is for seriously injured or ill patients. What may seem an emergency to the family, really isn't," explained Sullivan. "Then we have the family complaining when they're put on a waiting list."

The doctors and nurses are all professionally trained and are able to assess the patients condition with a short examination, in most cases.

"Many of us were in the medical field before we joined the Navy," remarked Sullivan. "What people don't understand is, the ER operates under a health care policy where the worst injured are attended first."

Space in the ER is divided between one trauma room, a cardiac room and five examination cubicles separated by curtains.

"We try to handle as many people as we can and still maintain each patient's privacy," declared Sullivan.

While the patient is examined, all unathorized persons are asked to stay in the air-conditioned waiting room. This makes it possible for the staff to concentrate on the injured person.

"As soon as possible after we've stabilized an individual, we inform the waiting family members of the patient's condition," stressed the staff nurse.

For patients brought in by ambulance, the vital signs and medical problems are radioed ahead. By the time the ambulance actually arrives, the staff is ready to take over.

"When we get swamped, tension builds, but our crew is professional and usually it doesn't cause problems," explained Sullivan. We stride forward and deal with each situation the best way we can."

This medical team of professionals prove time and time again with dedication and efficiency that lives can be saved, often at the last possible moment.

LIFE OR DEATH — Ambulances carry the base emergency medical teams when they respond to phone calls reporting emergencies on and off base. Once the team arrives at the accident site, the patient is stabilized and transported to the nearest hospital. (USMC photo by Cpl. L.S. Lewis)

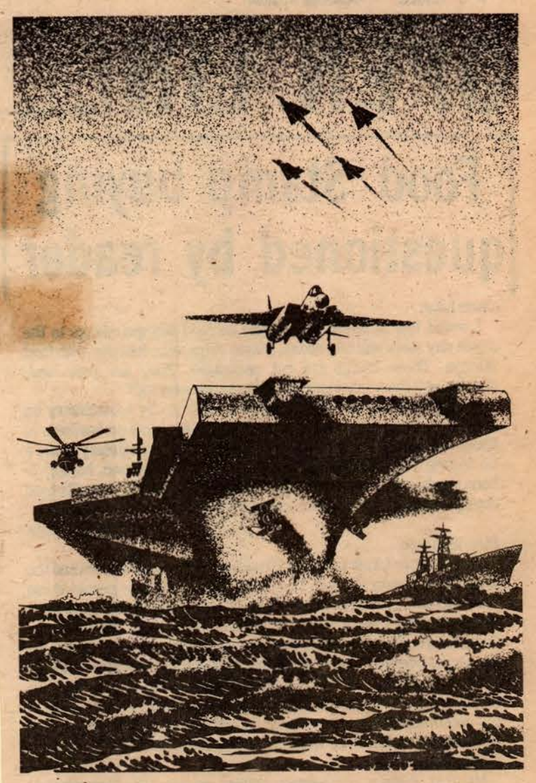
RIBBON CUTTING AT CHERRY POINT OF NEW OCCUPATIONAL/INDUSTRIAL HEALTH CLINIC - SEPTEMBER 1980

CAMP LEJEUNE, N.C.

GLOBE

"THE WORLD'S MOST COMPLETE AMPHIBIOUS TRAINING BASE"

Vol. 38, No. 41 Oct. 9, 1980



Navy celebrates 205 action years

By LCpl. Chris Hawthorne

Monday marks the 205th anniversary of the U.S. Navy. On Oct. 13, 1775, Congress approved a plan for purchasing and outfitting two naval vessels for the purpose of capturing British transports going to Canada.

In February 1776, the infant Navy set sail. Admiral Esek Hopkins had been assigned to destroy an armada at Chesapeake Bay with his eight ships. Then Hopkins heard of stockpiled powder and arms on New Providence Island in the Bahamas.

He sailed for the Bahamas, losing two ships to bad weather. On March 3, the Marines and sailors rowed ashore, marched overland and attacked the British fort. It marked the Marines' first amphibious landing.

Since their early childhood, the Navy and Marine Corps have grown up together, developing as close sister services of the sea.

Today, the Navy and Marine Corps are a unique team. From relief and rescue operations in the Caribbean, to increased U.S. military presence in the Indian Ocean, the Navy and Marine Corps stand side-by-side, protecting and serving our Nation's interests.

service to our nation," said MajGen. David Barker, commanding general, Marine Corps Base, in his birthday message to sailors here. "The service ties that bind the Navy-Marine Corps Team make the naval service a formidable and vital part of our nations defense."

Recognizing the team effort, the Chief of Naval Operations, Admiral T.B. Hayward remembered Marines in his 1980 Navy Birthday address. "As we celebrate the Navy's 205 Anniversary and pause to reflect on the past year and our Navy heritage, every member of the Navy-Marine Corps Team can properly take pride," Hayward stated.

In celebration, enlisted sailors here ean attend a cake cutting ceremony Oct. 17 at 6 p.m. in the Goettge Memorial Field House. Officers will hold a cake cutting Oct. 18 at 6:30 p.m. at the Paradise Point Officers Club.

CAMP LEJEUNE, N.C.

GLOBE

"THE WORLD'S MOST COMPLETE AMPHIBIOUS TRAINING BASE"

Vol. 38, No. 40 Oct. 2, 1980

Congratulations to the Naval Regional Medical Center on their eighth anniversary. Since Oct. 1, 1972, the center has provided vital medical services to the thousands of citizens of the Camp Lejeune community.

New Patient Contacts Services hear complaints, solve problems

Photo and story by
Cpl. L.S. Lewis

The Naval Regional Medical Center here has opened a new department whose sole purpose is to answer questions and solve grievances about the hospital's medical care.

Started in January, the Patient Contact Services here have representatives for every clinic at the Naval Hospital Medical Center. Each representative is responsible for handling all questions and complaints about his assigned clinic.

"If he can't solve the problem, it is brought to the attention of the clinic's supervisor," said Master Chief John F. Kelsey, command patient contact representative.

"If the supervisor can't supply a solution to the problem or question, it is brought to me. One way or another, the problem will be dealt with and solved, if possible," Kelsey explained.

The department here has added something extra to the program. In each clinic there is a photo of the clinic's representative and instructions for contacting him.

"Usually the patient contacts the duty corpsman and the clinic representative is then called," explained Kelsey. "Unfortunately, not many people know about us. Because of this, they go unhelped."

The purpose of the program is to improve the treatment and service at the hospital. Like most improvement programs, it can not help if problems are not brought to its attention.

Have problems or questions? Talk to one of the Patient Contact Services representatives. They're there to serve you.

HERE TO SERVE — Hospitalman First Class A.P. Roberts, a representative of the newly established Patient Contact Services at the Naval Regional Medical Center, speaks with Staff Sgt. Jose G. Lucio of Marine Corps Base.

New flu vaccine ready for influenza season

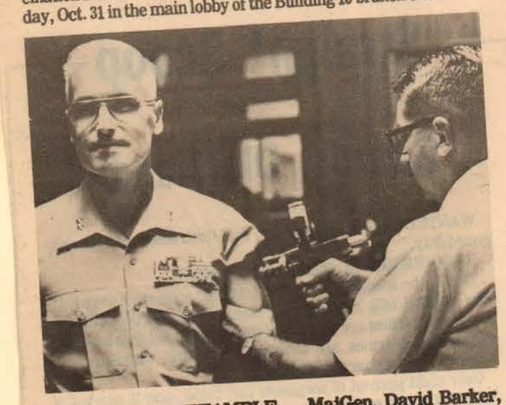
Marines and sailors here have begun receiving influenza vaccinations to insure they don't become victims of the 1980-81 flu season.

This year, everyone will receive a "reformulated" vaccine designed to counter Brazil, Bangkok and Singapore flu strains.

Most active duty personnel will be contacted by their respective commands and scheduled for the shots. Anyone who is not contacted may make an appointment for vaccination with Chief Hospitalman D.B. Miller at the Naval Regional Medical Center, base ext. 5707 or 2707. Personnel may also contact their area dispensary.

Dependents and retirees will be vaccinated at their own request. Appointments may be made at the Naval Regional Medical Center's immunization clinic Monday through Friday from 8 a.m. to noon and from 1 p.m. to 3 p.m. Tuesday, Wednesday and Friday.

Civilian employees are scheduled to receive voluntary vaccination from 1:30 p.m. to 3:30 p.m. Wednesday, Oct. 29 and Friday, Oct. 31 in the main lobby of the Building 15 branch clinic.



SETTING THE EXAMPLE — MajGen. David Barker, commanding general of Marine Corps Base here, is the first to receive his flu shot to open the 1980 Immunization Program. Chief Hospitalman D.B. Miller is administering the shot. (USMC photo by Cpl. Jane Valliere)

MEDVACs save lives

Story and photo by
Cpl. L.S. Lewis

The "MEDVAC" patient's heart beat slows and suddenly stops. Rushing to the patient's side, two Navy Corpsmen begin cardiopulmonary resuscitation, fighting all the while to keep their balance in the descending helicopter.

Once the helicopter lands and shuts off its engines, the two Corpsmen begin using a defibrillator. After the heart is shocked into beating again, the Corpsmen signal the crew chief to take off.

A life hung in the balance, but because of the Corpsmen's quick thinking and thorough training, the life was saved. There are six Corpsmen assigned to the Heart Station at the Naval Regional Medical Center here. They are flight-qualified to handle patients being medically evacuated, and they are ready to respond to a call 24 hours a day.

"Usually, patients are in stable condition when it is time to evacuate them. It's our job to keep them that way," explained Hospitalman Doug E. Wimer, MEDVAC Corpsman.

Before the Heart Station Corpsmen are allowed on MEDVAC missions, they are trained in all aspects of the job. At the NRMC's Intensive Care Unit, they assist doctors, while familiarizing themselves with the equipment. When on MEDVAC, they know how every piece of equipment works and if necessary, how to manually replace it.

"We get on-the-job-training in intensive care, and learn how to handle emergency situations that could occur while in the air," said Wimer.

On a MEDVAC, there are no doctors or nurses to turn to, except in very serious cases. The Corpsmen are totally responsible for the patient.

"It's a lot of responsibility," remarked Wimer. "I have to know everything about the emergency equipment. I've been in some complicated situations, but my training has enabled me to handle them with confidence."

"It's not unusual to get back from one mission and be immediately called out on another one," said Wimer.

Sometimes the Corpsmen go for two or three days at a time with only a few hours sleep.

"I have never regretted my decision to become a Corpsman, said Wimer. "There's no way to describe my feeling when I help to save a life. When you come right down to it, the patients need me," he added. "We are one more link in the medical team serving the Navy and Marine Corps families here."

GREAT RESPONSIBILITY — Hospitalman Doug E. Wimer prepares a syringe of medication for a patient being medically evacuated from the Naval Regional Medical Center, Camp Lejeune to the Naval Hospital at Portsmouth, Va. aboard a CH-53 "Sea Stallion" helicopter.

Navy birthday baby makes appearance

The first "Navy baby" born here after the Navy's birthday, Oct. 13, was Mark Anthony Dunson who made his appearance 12:24 a.m., Oct. 18.

His parents are HM1 and Mrs. Otis Dunson. Dunson is stationed with 2d FSSG.

The Camp Lejeune chapter of the Navy Relief Society presented the little guy with a special naval birthday layette. The layette included many items of clothing necessary for a new baby and was assembled especially for Mark by NRS Layette Volunteers.

WHO TURNED ON THE LIGHTS? — Little Mark squints but new Mommy, Mrs. Otis Dunson, smiles as she shows off her "Navy Birthday Baby". (USMC photo by Sgt. Jane Valliere)

HMCM W. P. COLVIN'S RETIREMENT
31 OCTOBER 1980

Doctor appointed

James F. Lyons, chief of the obstetrician and gynecologist service at the Naval Regional Medical Center at Camp Lejeune, has been appointed to a three-year term as vice chairman of the Navy section of the American College of Obstetricians and Gynecologists. The ACOG represents more than 22,000 physicians.

DEVIL PUP — Born Nov. 10 at 1:30 a.m., Ryan David, son of Pfc. and Mrs. Jeffery B. Bradley, became the first baby born here on the 205th birthday of the Marine Corps. Little Ryan came into the world at the Naval Regional Medical Center weighing a healthy 8 pounds, 6 ounches. His father, Pfc Bradley, works with Base Game Warden's Office. Ryan is wearing a hand-made bunting which was presented to his mother, Patricia, Nov. 12 by the Camp Lejeune Navy Relief Society. (USMC Photo by Cpl. Lewis)

RINGING IN THE NEW YEAR — While party goers continued to celebrate here, a healthy 9-pound, 4-ounce girl was born to Cpl. and Mrs. Harold G. Wern at the Naval Regional Medical Center at 6:42 a.m. New Year's Day. Rachael Jaqueline is the official New Year's Baby of the base. Her mother, Debra A. Wern has been presented with a special New Year's layette from the Navy Relief Society. The hand-made baby clothes will come in handy when Cpl. Wern of Base Special Services, welcomes home his new family. (USMC photo by Cpl. L.S. Lewis)

April 30, 1981 Globe 11

Sport Shorts

HOLE IN ONE — Senior Chief Ronald Tenley hit a hole in one April 11 on the 170 yard 12th hole of the Paradise Point Golf Course. Tenley works in the administration office of the Naval Regional Medical Center. The golfer of ten years was playing a foursome with friends who witnessed the shot.

"CAMP LEJEUNE GLOBE" 4 December 1980

Hospital construction 'operates' on schedule

Story and photos
By Sgt. T.R. Lane

Construction of the new $39 million, ultra-modern hospital here, which will replace the 37-year-old Navy Regional Medical Center, is "right on schedule," according to the project's resident officer in charge.

Cmdr. Richard E. Carlson said that despite a couple of delays, the basic structural frames of the hospital are now 60 percent complete and should be finished by the end of the year.

The 162-acre hospital complex is scheduled to be completed in the spring of 1982.

"Hurricane David in September of 1979 and the snowstorm in March slowed us down, but since then, everything has been progressing according to plans," said Carlson.

He added that the prior planning and cooperation of the contractors building the complex have greatly contributed to the current success of the project.

"Because of the thoroughness of the plans for the project, we have had to deviate from their specifications very little," said Carlson. "That factor, as well as the cooperation of the contracting firm, has practically eliminated any costly or untimely delays and allowed us to continue the project on, and even ahead of schedule."

Located near the intersection of Brewster Boulevard and Stone Street, the complex will have approximately 450,000 square feet of floor space. It will be able to provide impatient care for 205 people and office space for 80 physicians, including one or two examination rooms per doctor, depending on specialty.

In addition to the expanded facilities, the hospital will feature a nuclear medicine service and increased services in the laboratory and radiology sections.

Another modern addition to the complex will be an Engineering Management Control System, a computer which will control the lights, doors, heating and cooling systems and all the security devices of the hospital.

PIECING TOGETHER THE PUZZLE — Camp Lejeune residents will soon have an ultra-modern hospital care for their medical needs when the new Navy Regional Medical Center being built here is completed in 1982.

HN STEPHENYE SEAY - BLUEJACKET OF
THE QUARTER - APRIL - JUNE 1981

Field Med. student learns that getting to the wounded is often half the battle.

Corpsmen: don't leave home without them

By LCpl. Stephen Whitfield

On June 17, 1898, President William McKinley approved an act of the 55th Congress establishing the Hospital Corps of the United States Navy, to consist of pharmacists, hospital stewards, hospital apprentices first class and hospital apprentices.

Wednesday, June 17 marks their 83rd birthday.

Many Marines serving today can testify to the bravery that seems to be part of the basic nature of corpsmen in combat. The words of HN2 Chris Pyle in a letter to his mother while attending Field Medical School here in the late '60's reflect that quality.

"Someday I will see before me a wounded Marine. I will think of all kinds of things but my training has prepared me for just that moment. I really doubt if I will be a hero but to that Marine I will be God. I am hoping that no one will die while I am with him. If he's wounded in the middle of a rice paddy, you can bet your bottom dollar that, with whatever God gave me for power, I will try, until my life is taken, to help save him and any others."

On May 28, 1969 HN2 Pyle was killed while attending a wounded Marine in Vietnam.

The Hospital Corps carries out its mission in peace with the same dedication to duty.

Here at Camp Lejeune, Field Medical Service School trains corpsmen in techniques of field medicine and basic military subjects meeting the requirements of the Fleet Marine Force. Training is tough, with emphasis on combat survival skills, field medical and dental support, emergency medical care, casualty support, evacuation and preventive medicine.

Recent training trends provide an ongoing effort to maintain the "force in readiness" concept, according to Lt. William A. Silva, training officer at the school.

"Not only does this realistic training make the corpsman more combat ready, it also helps him realize the true meaning of the Navy-Marine Corps Team," explained Lt. Silva, who has served as a corpsman and Seal.

The 2nd Medical Bn., 2nd FSSG provides for collection, emergency treatment, temporary hospitalization, and evacuation of casualties. They also plan, supervise and perform timely protective measures for control of diseases common to field operations.

The battalion's companies serve Camp Lejeune at three locations: Co. A at River Road Branch Clinic, Co B at Building 15, and Co. C at Camp Geiger.

Hospital corpsman also serve at the Naval Regional Medical Center at Camp Lejeune in general clinical and hospitalization units, and in special clinics and sub-specialty services. They perform administrative functions that are expected of personnelmen, yeomen, disbursing clerks and supply.

They work on equipment that electronic technicians and radiomen would normally be called upon to repair. They also perform some security functions.

The corpsmen serving with Division perform their duties with the various combat units in the field.

Hospital Corps' history spans almost two hundred years from the "loblolly boys" who served on ships during the undeclared war against France in 1799 to the contemporary hospital corpsman.

Through history and personal experience, Marines are well aware of the valor and courage of the corpsman. During World War II a total of 15 Medals of Honor were awarded to Navy enlisted men. Of those, seven were bestowed upon hospital corpsmen acting to save the lives of Marines.

As Secretary of the Navy James Forrestal stated in his commendation for their service in the war,..."that others might live, your fellow corpsmen have given their lives; 889 of them were killed or mortally wounded. Others died as heroically from diseases they were trying to combat. In all, the Corps' casualty list contains 1724 names, an honor roll of special distinction because none of them bore arms."

Pharmacist's Mate Second Class John H. Bradley was a corpsman serving with 2nd Bn. 28th Marine Regiment when he assisted five Marines in raising the flag on the crest of Mount Suribachi, Iwo Jima on February 19, 1945. That moment, immortalized by a well-publicized Associated Press photograph is an example of the honor and courage of the corpsman, and of the Navy-Marine Corps Team.

During the Korean War, corpsmen earned further respect from the Marines whose lives many times depended on the courage and quick thinking of the sailors. Corpsmen earned five Medals of Honor during that conflict.

The tradition of bravery continued in Vietnam. From rice paddies to mountain plains, the cry of "Doc!" was heard and responded to regardless of danger.

The tradition is passed on to the contemporary hospital corpsman.

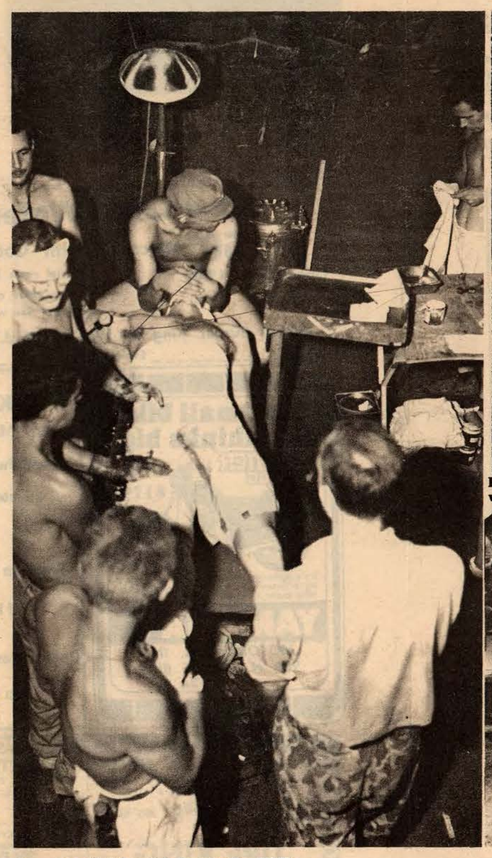
He not only must be knowledgeable of how to treat wounds caused by advanced technology of potential enemies; he also must be aware of the expanding technology in the field of medicine. With the training and tradition of today's Hospital Corps, the challenge is well met.

An anonymous quotation, framed on a wall in the Second Medical Battalion's S-4 shop sums up the corpsman's way of thinking toward this challenge:

"It is the duty of a Hospital Corpsman to wait in obscurity for a crisis that may never come;but when it does come, it is his duty to give it all he has."

As we observe the Naval Hospiltal Corps' 83rd birthday, we acknowledge their valiant contribution to the Marine Corps and their country.

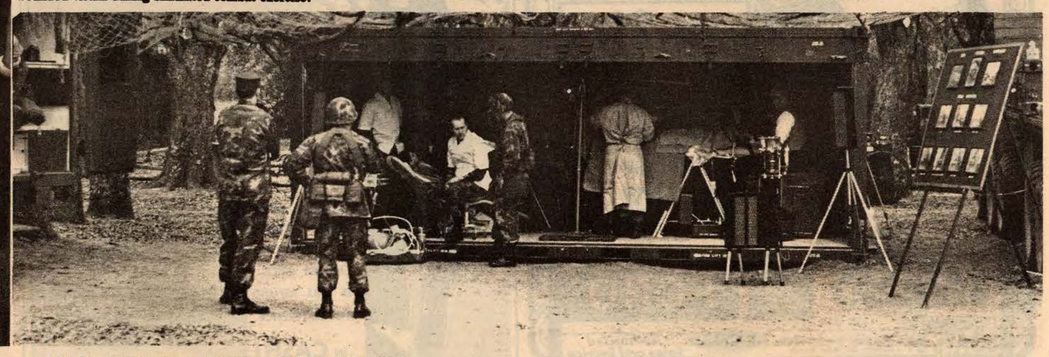
HM3 Peter S. Ashmore applies battle dressing to the "wound" of HM3 Kris Parker during a field exercise.



Surgery in a field hospital, Bougainville, WWII

Lead stretcher bearer HN James F. Morris transports wounded victim during simulated combat exercise.

HM3 Peter Ashmore treats casualty for shock during simulated combat exercise.



2nd Med Bn. displays gear and procedures during a static exhibit.

GLOBE
CAMP LEJEUNE, N.C.
"THE WORLD'S MOST COMPLETE AMPHIBIOUS TRAINING BASE"
Vol. 36, No. 18
May 7, 1981

HAPPY BIRTHDAY — A Navy nurse cuddles a pint-size patient. Pediatric nursing is only one of the diversified skills shared by the Navy Nurse Corps, which celebrates its 73rd anniversary Wednesday.

PUBLIC WORKS SERVICE PERSONNEL
RECEIVING AWARDS - 7 JULY 1981

SECRETARIES FROM VARIOUS SERVICES
RECEIVE AWARDS - 7 JULY 1981

FOOD MANAGEMENT SERVICE PERSONNEL
RECEIVING AWARDS - 7 JULY 1981

OUTSTANDING AWARD PRESENTATION -
BRANCH CLINICS - 7 JULY 1981

PATIENT SERVICES PERSONNEL
RECEIVING AWARDS - 7 JULY 1981

OPERATING MANAGEMENT PERSONNEL
RECEIVING AWARDS - 7 JULY 1981

Naval Regional Medical Center
Camp Lejeune, North Carolina

DEPARTMENT OF THE NAVY

Change of Command Ceremony
1300
16 July 1981

CAPTAIN JAMES L. HUGHES, MC, USN

Outgoing Commanding Officer

Captain James Lewis Hughes, MC, U. S. Navy, was born on 4 January 1930 in Cumberland, Maryland. He attained his Bachelor of Science Degree from Georgetown University in 1951 and his M. D. from the University of Maryland School of Medicine in 1955. He subsequently served an internship at Saint Agnes Hospital, Baltimore, Maryland and completed residency training in Pediatrics at the U. S. Naval Hospital, Chelsea, Massachusetts.

Captain Hughes entered the Navy in 1957, serving at Naval Hospitals in Cherry Point, N. C.; Chelsea, Massachusetts and Camp Lejeune, N. C. In 1965 he was assigned to the Naval Regional Medical Center, Portsmouth, Virginia, where he served as Chairman of the Department of Pediatrics from 1967-1975. Transferred to the Naval Regional Medical Center, Jacksonville, Florida as Director of Clinical Services, he had the privilege of being Interim Commanding Officer from May to July 1976. He returned to Camp Lejeune in 1977 and has been Commanding Officer of that Naval Regional Medical Center since 22 July 1977.

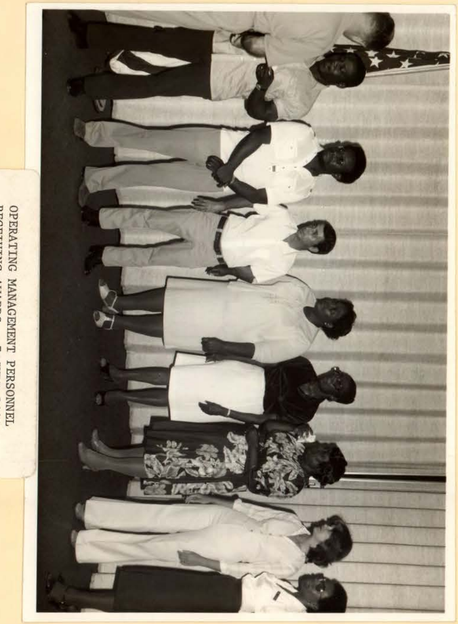
He received Board Certification in Pediatrics in 1962 and numbers among his Professional Society Memberships the American Academy of Pediatrics and the Association of Military Surgeons of the United States. He was Chairman of the Military Section of the Academy of Pediatrics from 1967-1971 and consultant to the King's Daughters Children's Hospital in Norfolk, Virginia from 1970-1975. In 1974 and 1975 he served on the Pediatric Faculty of the Eastern Virginia Medical School. Upon retirement he will assume a Professorship in Pediatrics at the East Carolina University School of Medicine.

Captain Hughes married the former Marlene Emlyn Bayne at Port-of-Spain, Trinidad in 1956. They are blessed with five children, a daughter-in-law and a very special granddaughter.

PATIENT SERVICES PERSONNEL
RECEIVING AWARDS - 7 JULY 1981

FOOD MANAGEMENT SERVICE PERSONNEL
RECEIVING AWARDS - 7 JULY 1981

PUBLIC WORKS SERVICE PERSONNEL
RECEIVING AWARDS - 7 JULY 1981



OPERATING MANAGEMENT PERSONNEL
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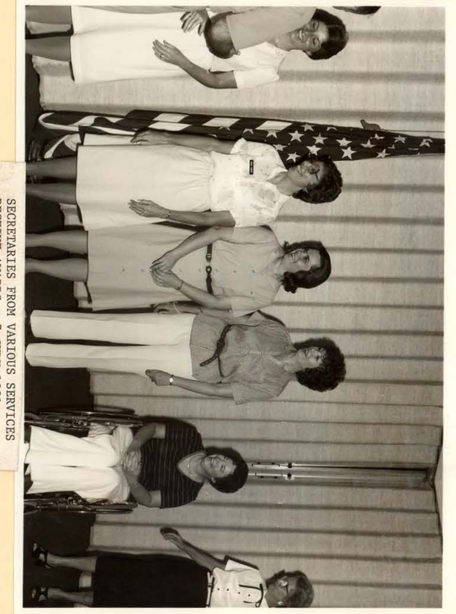
OUTSTANDING AWARD PRESENTATION -
BRANCH CLINICS - 7 JULY 1981



SECRETARIES FROM VARIOUS SERVICES
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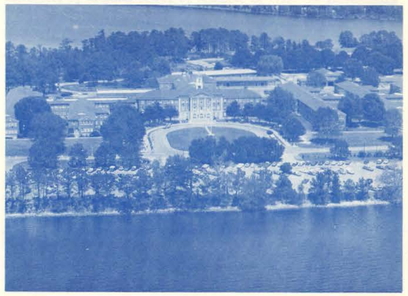


NAVAL REGIONAL MEDICAL CENTER

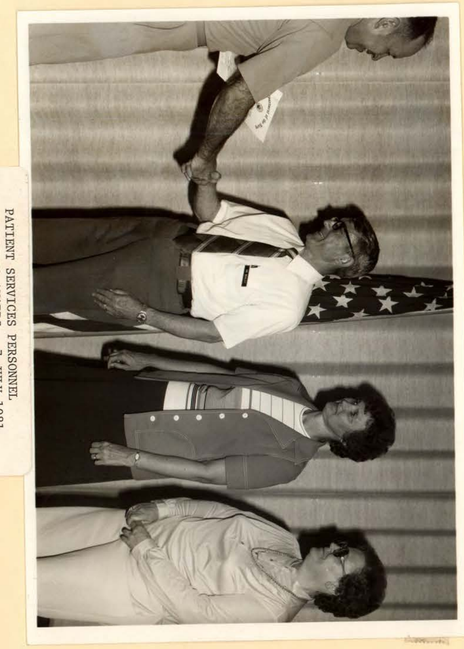
Camp Lejeune, N. C. 28542

PROGRAM

Arrival of Official Party	
Attention	Battalion Commander
Arrival Honors	Band
National Anthem	Band
Invocation	LCDR Harold D. Palmer, CHC, USN
Inspection of Troops	Captain James L. Hughes, MC, USN
Introduction	Commander N. C. LaChapelle, MSC, USN
Remarks	Rear Admiral Melvin Museles, MC, USN Asst. Chief for Professional Development Bureau of Medicine and Surgery
Remarks and Reading of Orders	Captain James L. Hughes, MC, USN
Reading of Orders and Remarks	Captain John N. Rizzi, MC, USN
Post Side Boys	
Anchors Aweigh, Marine Hymn	Band
Benediction	LTJG Robert A. Valko, CHC, USNR
Navy Hymn	Band
Attention	Battalion Commander
Official Party Departs	
Dismissal of Troops	

Guests and Staff are cordially invited to a reception in the Medical Center Bachelor Officers' Quarters immediately following ceremony.

Music by Second Marine Aircraft Wing Band
Marine Corps Air Station, Cherry Point, N. C.



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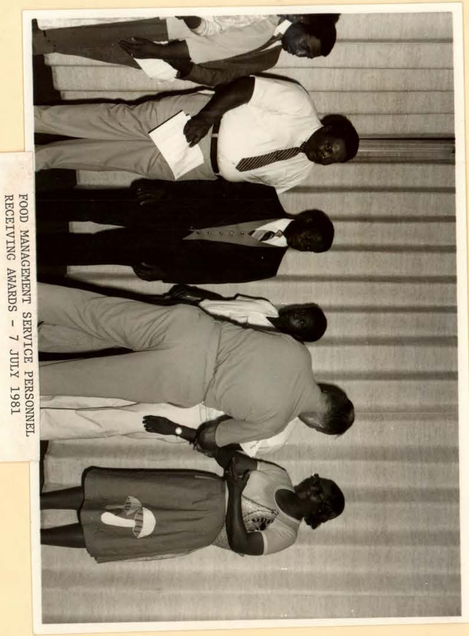

FOOD MANAGEMENT SERVICE PERSONNEL
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PUBLIC WORKS SERVICE PERSONNEL
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OPERATING MANAGEMENT PERSONNEL
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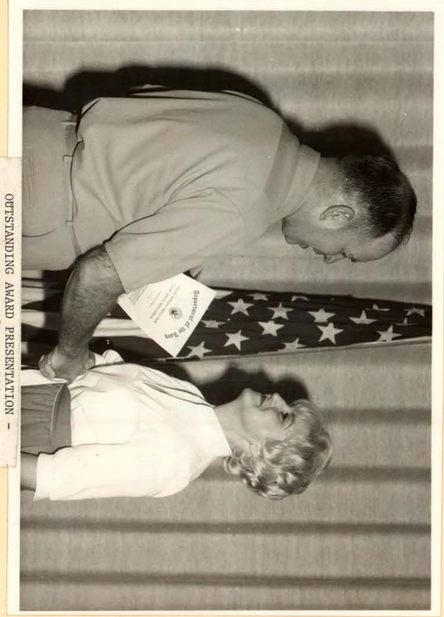
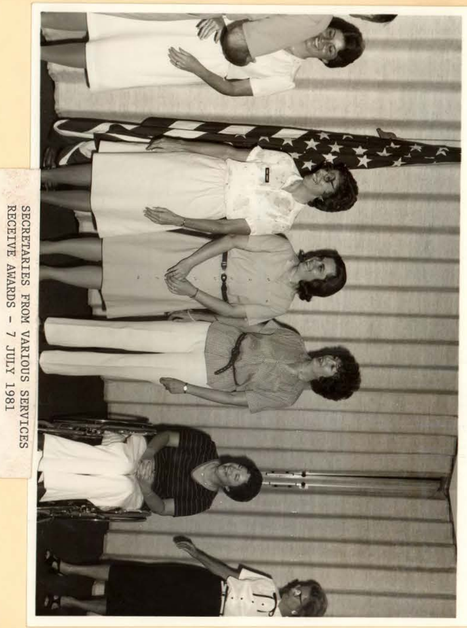


OUTSTANDING AWARD PRESENTATION -
BRANCH CLINICS - 7 JULY 1981



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RECEIVING AWARDS - 7 JULY 1981

CAPTAIN JOHN N. RIZZI, MC, USN

Incoming Commanding Officer

Captain John N. Rizzi, MC, U. S. Navy, was born on 18 January 1929 in Jamaica, New York. He received his Bachelor of Science Degree from Georgetown University, Washington, D. C., and was graduated from the New York Medical College in 1954. After interning at the Mary Immaculate Hospital and having served his residency in Obstetrics and Gynecology at the Queens General Hospital, both in Jamaica, New York, he came on Active Duty as one of the first "Berry" doctors. His first tour was at Naval Hospital, Newport, Rhode Island, followed by a short stint with DESLANT, and a tour at Naval Hospital, St. Albans, New York. He then entered private practice for several years but returned to Active Duty, and following a protracted tour at Naval Regional Medical Center, San Diego, he was ordered to the Bureau of Medicine and Surgery in 1977. While in Washington, Captain Rizzi served successively as Director of the Reserve Division, with Additional Duty to Recruiting Command; Special Assistant to the Surgeon General for Professional Affairs and Chief of Staff to the Surgeon General.

Captain Rizzi comes to Camp Lejeune following two years as Director of Clinical Services at the Naval Regional Medical Center, Portsmouth, Virginia. He was promoted to his present rank on 2 June 1971.

Captain Rizzi is a Diplomate of the American Board of Obstetrics and Gynecology; a Fellow of the American College of Obstetricians and Gynecologists; a Fellow of the American College of Surgeons; a member of the Royal Society of Medicine, a member of the Association of Military Surgeons of the United States, a member of the Society of Medical Consultants to the Armed Forces, and a member of the American Medical Association.

Captain Rizzi is married to the former Joyce Ann Tuerk and has two daughters.

"CAMP LEJEUNE GLOBE" July 23, 1981

LCpl. Stephen Whitfield

Captain retires

Navy Capt. James L. Hughes reads his orders to relinquish command of the Naval Regional Medical Center to Capt. John N. Rizzi, during a July 16 ceremony here. Capt. Hughes, who had been the commanding officer since July 1977, will retire after 24 years of service. Rizzi recently arrived here after two years at Naval Regional Medical Center, Portsmouth.

The Globe
July 16, 1981 **19**

Changes of command

Capt. John N.Rizzi (MC) USN, takes command of the Naval Regional Medical Center today from Capt. James L. Hughes (MC), USN. The ceremony is slated for 1 p.m. at NRMC. Capt. Rizzi comes to Camp Lejeune after a tour as CO of the NRMC, Portsmouth, Va.

CHANGE OF COMMAND - 16 JULY 1981
CAPTAIN JAMES L. HUGHES RELIEVED
BY CAPTAIN JOHN N. RIZZI

Naval Regional Medical Center
Camp Lejeune, North Carolina

DEPARTMENT OF THE NAVY

Change of Command Ceremony
1300
16 July 1981

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CHANGE OF COMMAND - 16 JULY 1981
CAPTAIN JAMES L. HUGHES RELIEVED
BY CAPTAIN JOHN N. RIZZI

BLUEJACKET OF THE QUARTER - A. DETONE - JULY - SEPTEMBER 1981

BLUEJACKET OF THE QUARTER - HM2 RODNEY M. HOBBS - OCTOBER - DECEMBER 1981

The Surgeon General of the U. S. Navy visited Camp Lejeune last week. Vice Admiral J. William Cox has some interesting predictions concerning medical care for combat Marines.

Page 3

General meets the press

COMBAT MARINES CAN expect more medical lp should they be ordered into a shooting conflict the near future. That prediction and several others me Oct. 8 during a meeting of local reporters and e Surgeon General of the U. S. Navy, Vice Admiral William Cox.

The Navy's top physician visited Camp Lejeune t week as one stop on a whirlwind tour of medical ilities around the world. During a news conference d at Camp Lejeune's Navy Regional Medical nter, Adm. Cox spoke of the necessity to keep dical treatment as close as possible to the Fleet rine Force. He said quick and effective medical port is vital to the U. S. defense strategy of combat sustainability.

"Our job is to have our skills and capabilities, supplies and facilities as close as possible to the action," commented Adm. Cox. "Only by doing that can we sustain what we are seeking: a powerful, flexible, mobile combat force."

KEEPING EXPERT MEDICAL help close to a front where it would be most needed means more physicians and Hospital Corpsmen must be recruited and retained. Adm. Cox indicated some 98 percent of the billets for FMF Corpsmen are currently filled, but more deployable aid-men are needed. "Beginning this fiscal year and projected into future years," commented Adm. Cox, "we will acquire significant additional spaces for Hospital Corpsmen." The Surgeon General did not get more specific in discussing the number of additional Corpsmen nor the commands to which they might be attached. He did, however, indicate that increasing the number and experience-levels of combat Corpsmen was a task that would involve intensive recruiting and retention efforts.

Adm. Cox voiced the opinion that Fleet Marines play an important role in providing job satisfaction for FMF Corpsmen. "It is traditional for Marines to carry out the responsibility of making the Corpsmen serving with them feel at home," he said. "Marines should continue to indicate to them (Corpsmen) individually that they are an extremely essential component of the unit."

The Surgeon General left Camp Lejeune Oct. 9 to continue his inspection tour. He has been to Navy facilities in the Western Pacific and the United States. He will inspect medical service facilities in Europe as the final leg of his tour. Adm. Cox was optimistic about his observations to date. "On a scale of one to 100," he commented, "the morale, the understanding of individual roles within the medical department, the dedication of the people and their capability to do their job all adds up to about 99 out of that 100."

Page 3
"Camp Lejeune GLOBE"

Lady golfer walks softly but carries a big club enroute to Interservice crown. Navy Lieutenant Shelley Savage, though small in stature, lives up to her name on the fairways.

Page 19

f queen
nd...
are on the line

the petite Navy lieute- ner face and her blue eyes sparkled at the thought her latest success, the 1981 Interservice Golf crown.

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It was the second Interservice win for Savage in as many tries, the first coming in 1978.

"The Navy cut back on Interservice golf competition in '79 and '80, so we didn't have representatives in those two years," said Savage. The Trenton Mich. native won the regional competition for those years.

THE 5-FOOT-2-INCH nurse began her golf career at the early age of five. "My father gave me a couple of clubs that I played around with," said the 27-year-old. "I really didn't get serious about the sport until I was 11."

Once the golfer hit high school the awards started flowing in. "My biggest victory in high school was winning the Junior District Golf Association of Detroit," said Lt. Savage. She won the honor in 1969 and '70.

After high school Savage entered nursing school at the University of Michigan. "I wanted to continue my game and compete on the college level, but I didn't really have the time. It was hard to compete with the student athletes, they had all the time...that's why they were there, to play golf," said the quiet-spoke nurse.

To finish her nurse training, Lt. Savage transferred to the University of Miami, Florida. "After college I decided to join the Navy, I had a friend that went into the Navy, she seemed to enjoy it, so I joined." she said.

THE YOUNG LIEUTENANT'S game got back in full swing upon entering the Navy. Last year Lt. Savage took eighth in the Eastern Amature tournament at South Pines, N.C. "The top college players were in this tournament, I felt good about eighth place," she said.

The only problem the small golfer has is her size. "I don't hit the ball very far, I'm not strong enough," said the Navy champion.

When the diminutive nurse is not working with patients in the Naval Regional Medical Center she can be found at the Paradise Point Golf course with clubs on her shoulder roaming the greens improving her game.

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GOLFERS MAY WANT to stop and watch the style of the small champion that has, and will continue to be one of the top military golfers in the country.

12

BLUEJACKET OF THE QUARTER - HM2 RODNEY M. HOBBS - OCTOBER - DECEMBER 1981

Surgeon General meets the press

COMBAT MARINES CAN expect more medical help should they be ordered into a shooting conflict in the near future. That prediction and several others came Oct. 8 during a meeting of local reporters and the Surgeon General of the U. S. Navy, Vice Admiral J. William Cox.

The Navy's top physician visited Camp Lejeune last week as one stop on a whirlwind tour of medical facilities around the world. During a news conference held at Camp Lejeune's Navy Regional Medical Center, Adm. Cox spoke of the necessity to keep medical treatment as close as possible to the Fleet Marine Force. He said quick and effective medical support is vital to the U. S. defense strategy of combat sustainability.

"Our job is to have our skills and capabilities, supplies and facilities as close as possible to the action," commented Adm. Cox. "Only by doing that can we sustain what we are seeking: a powerful, flexible, mobile combat force."

KEEPING EXPERT MEDICAL help close to a front where it would be most needed means more physicians and Hospital Corpsmen must be recruited and retained. Adm. Cox indicated some 98 percent of the billets for FMF Corpsmen are currently filled, but more deployable aid-men are needed. "Beginning this fiscal year and projected into future years," commented Adm. Cox, "we will acquire significant additional spaces for Hospital Corpsmen." The Surgeon General did not get more specific in discussing the number of additional Corpsmen nor the commands to which they might be attached. He did, however, indicate that increasing the number and experience-levels of combat Corpsmen was a task that would involve intensive recruiting and retention efforts.

Adm. Cox voiced the opinion that Fleet Marines play an important role in providing job satisfaction for FMF Corpsmen. "It is traditional for Marines to carry out the responsibility of making the Corpsmen serving with them feel at home," he said. "Marines should continue to indicate to them (Corpsmen) individually that they are an extremely essential component of the unit."

The Surgeon General left Camp Lejeune Oct. 9 to continue his inspection tour. He has been to Navy facilities in the Western Pacific and the United States. He will inspect medical service facilities in Europe as the final leg of his tour. Adm. Cox was optimistic about his observations to date. "On a scale of one to 100," he commented, "the morale, the understanding of individual roles within the medical department, the dedication of the people and their capability to do their job all adds up to about 99 out of that 100."

Page 3
"Camp Lejeune GLOBE"

Interservice golf queen just putts around...

except when titles and crowns are on the line

Story and photo by Sgt. Jim Brown

THE CONCENTRATION ON her face could be felt as the petite Navy lieutenant stroked a 10-foot putt straight into the hole. A bright smile flashed across her face and her blue eyes sparkled at the thought her latest success, the 1981 Interservice Golf crown.

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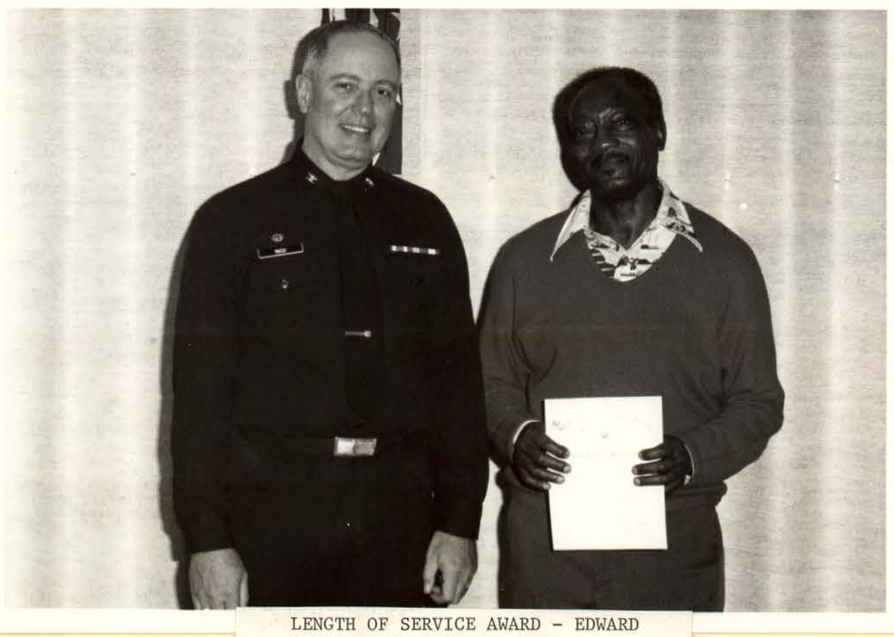
12

LENGTH OF SERVICE AWARDS - 12/16/81
EDNA WINN, MINNIE RUSS,
VELMA DUFF



LENGTH OF SERVICE AWARD - EDWARD
MORRIS - 16 DECEMBER 1981

MARGARET CARR - LENGTH OF SERVICE
AWARD - 16 MARCH 1982

VICTORIA CHASTEN - LENGTH OF
SERVICE AWARDS - 16 MARCH 1982

BLUEJACKET OF THE QUARTER -
JANUARY - MARCH 1982
HN D. L. GIBSON

LUDELL SHEPARD - LENGTH OF SERVICE
AWARD - 16 MARCH 1982

WILLIAM SHARPE - LENGTH OF SERVICE
AWARD - 16 MARCH 1982

LENGTH OF SERVICE AWARDS - 16 MAR 82

Talk about 'Old Corps'

Boot camp in Philadelphia, leggings and the sights of Belleau Wood are the memories of former Marine Jimmy Killian

by Sgt. Chuck Henry
GLOBE Staff Reporter

Things were different when Jimmy Killian was a Marine. Privates pulled down a whopping $14.80 a month, before $10 was taken out for insurance and liberty bonds. There was no boot camp in 1917 either. Marines didn't even wear boots.

Jimmy Killian, a spry 82 and still full of sea stories, served as a Marine during World War I. Today, the salty Swansboro resident reminisces about the Corps aided by yellowing photos of a 17-year-old geared to take on Kaiser Bill's best.

"I was young; wantin' to get away from home," recalled the son of immigrant parents. His father was born in Germany, his mother in England. In 1917 as America teetered on the brink of entering the war in Europe, the Killians were living in Buffalo, N.Y., while the two nations of their ancestry fought.

Adventurous Jimmy had been interested in the military for some time.

"I had been a member of what they called the Home Contingent, kind of a national guard unit in New York when I was a kid. When the U.S. was

The young New Yorker was issued a dress blue Marine uniform. "Shortly after that, though, the Marine Corps changed its issue and we received wool forest green uniforms for dress and khakis to wear in combat. They also gave us the old doughboy helmets; they were just like big steel hats. We wore high-top, hob-nail shoes and laceable leggings, too," he recalled.

Recruit training then was not as formalized as it is today. "We didn't have all this fancy stuff. The Marine Corps has quonset hut barracks and a rifle range at Fairmont Park in Philadelphia and another place like it in New Jersey. I spent about a month at Fairmont shooting, learning to march and doing things like that. The first time I fired, I shot marksman. A little later I earned my rifle expert badge."

Although less structured, WW I-era recruit training wasn't any easier than the modern version. "Most of our instructors were 20 to 25-year-old buck sergeants," remembered Killian, "and they were tough as nails."

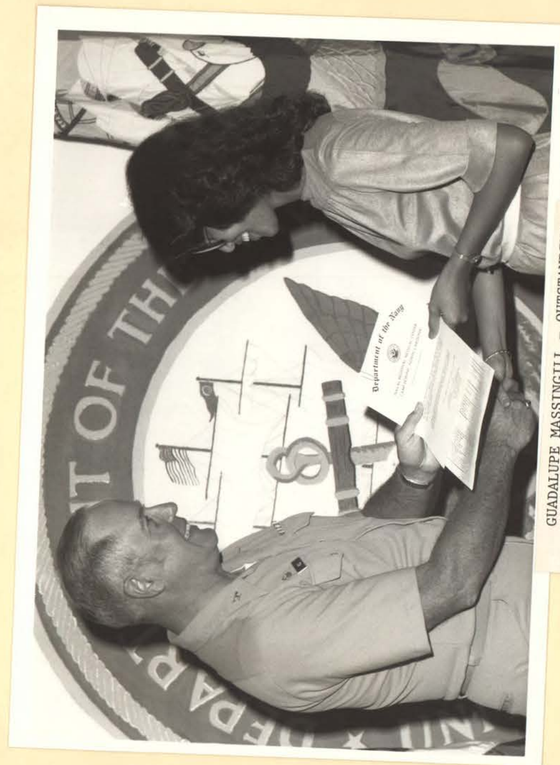
Guard duty at the New Jersey communication center that handled all Navy U.S.-to-Europe contact

fire. There were bodies strewn everywhere, too, on top of houses, in trees...everywhere."

Private Killian and his new buddies in Fifth Marines occupied land secured by veterans and braced for a German counter attack that never materialized.

In the field, the 17-year-old Marine saw an officer or two, but not many. "As far as I was concerned, the sergeant major was boss of the whole works," said Killian, who as a young Marine recalls being aw-

OUTSTANDING PERFORMANCE CERTIFICATES
16 JULY 1982 - CONNIE FERGUSON,
JAN ROSE, JEAN SMITH, KATHY TOOTLE,
PAULINE WALTERS, WARREN WHALEY



GUADALUPE MASSINGILL - OUTSTANDING
PERFORMANCE CERTIFICATE - 16 JUL 82

BLUEJACKET OF THE QUARTER -
APRIL - JUNE 1982 - HM2 POWERS

PICTURE PRESENTED BY MGEN COOPER
TO NAVAL HOSPITAL - 2 JULY 1982

KATE PARKER - OUTSTANDING PERFOR-
MANCE CERTIFICATE - 16 JULY 1982

GEORGAN HADLEY, ELLIE HESSE,
THOMAS SIMPSON

PERFORMANCE AWARDS - 16 JULY 1982

SUSTAINED SUPERIOR PERFORMANCE
AWARDS - 16 JULY 1982
GLENDA PROVOST, BERNICE MIKEAL,
NANCY THOMAS

MARY BURNS - OUTSTANDING PERFORMANCE
CERTIFICATE - 16 JULY 1982

MARY GILBERT - LENGTH OF SERVICE
AWARD - 16 JULY 1982

GUADALUPE MASSINGILL - LENGTH OF
SERVICE AWARD - 16 JULY 1982

EARSEY MARKS/WILLIAM BASS -
LENGTH OF SERVICE AWARDS - 16
JULY 1982

ELLIE HESSE - LETTER OF COMMENDA-
TION - 16 JULY 1982

Salty symbol marks milestone in NRMC progress

When the NRMC flagpoles were erected, Medical Corps sailors exercised an old Navy tradition by placing coins (see inset) at the base of each.

by Cpl. Erik Hassenbein
GLOBE Staff Reporter

ANOTHER MILESTONE IN the construction of Camp Lejeune's new Navy Regional Medical Center was reached July 21 when a silver dollar was placed at the base of each of the hospital's three flagpoles. The silver dollars were laid during a traditional Mast Stepping Ceremony. The coins honor the Chief of Naval Operations, Commandant of the Marine Corps and Surgeon General of the Navy.

The stepping of a mast is an ancient naval custom of placing coins at the foot of a mast when a ship is built. This tradition dates from antiquity and comes from the old Roman custom of placing coins in the mouths of the dead to pay their way to Charon for passage across the River Styx. If the ship should ever meet with a mishap at sea, the coins under its mast ensured that the fare for all hands was paid. Since the hospital is not equipped with masts, the coins were placed under the flagpoles.

Taking part in the ceremony was Major General Al Gray, commanding general, 2nd Marine Division, who represented the Commandant; Captain John N. Rizzi, Comanding Officer, NRMC, represented the Chief of Naval Operations, and Commander H. E. Phillips, who represented the Surgeon General of the Navy.

THE HOSPITAL, COSTING more than $39 million, is being built on a 162-acre site near Northeast Creek. The main building of the new NRMC will encompass 420,000 square feet of floor space.

"The hospital consists of a four-story nursing tower fronted by a two-story clinical and support building," said Rizzi. "The most significant aspect in the design is the intention of segregating access and circulation of people in the building."

The hospital commander explained that the facility will provide space for 205 impatients, with that area expanding to accommodate another 31. Also included will be extensive general and specialty care outpatient clinics.

"WE WILL ALSO have space for 80 health care practitioners in suites consisting of an office and one or two examination rooms, depending on the specialty," the captain explained. "In addition, a new Nuclear Medicine Service and an expanded laboratory and radiology service will give the hospital the latest diagnostic capabilities."

According to Navy Lieutenant David Wynkoop, Assistant Construction Liaison Officer and project manager, the hospital's construction has progressed very well. "It will be complete in late October and we will start moving in the early part of November. By February of 1983 we will be completely moved in and the first patients will start arriving."

PERSONNEL INSPECTION - 21 JUL 1982

MILDRED MURRILL RETIREMENT -
22 JUL 1982

The new replacement hospital at NRMC Camp Lejeune

Mast Stepping Ceremony for Camp Lejeune

CAPT John N. Rizzi, MC, USN CDR H.E. Phillips, MSC, USN LT D.A. Wynkoop, MSC, USN

On 21 July 1982, another milestone in the construction of the new naval regional medical center at Camp Lejeune was reached in a Mast Stepping Ceremony during which silver dollars were placed at the base of the hospital's flagpoles honoring the Chief of Naval Operations, Commandant of the Marine Corps, and Surgeon General of the Navy.

The stepping of a mast is the ancient naval custom of placing coins under the foot of a mast at the time a ship is built. This tradition dates from antiquity and derives from the old Roman custom of placing coins in the mouths of the dead to pay their way to Charon for passage across the River Styx. If the ship should ever meet with a mishap at sea, the coins under its mast insured that the fare for all hands was paid.

Taking part in the ceremony were MAJGEN A.M. Gray, Jr., Commanding General, 2nd Marine Division, representing the Commandant of the Marine Corps; CAPT John N. Rizzi, Commanding Officer at NRMC Camp Lejeune, representing the Chief of Naval Operations; and CDR H.E. Phillips, Medical Construction Liaison Officer, representing the Surgeon General of the Navy. The new facility, now nearing completion, will replace the old hospital built at Hadnot Point during World War II.

Dr. Rizzi is Commanding Officer, NRMC Camp Lejeune, NC. CDR Phillips is Military Construction Liaison Officer of the project. LT Wynkoop is Assistant Military Construction Liaison Officer.

The design of the facility incorporates the most modern concepts in hospital operations, including a centralized material management center based on a modular material handling and casework system that will provide daily delivery of all medical-surgical supplies and linen required to operate the hospital. Camp Lejeune is the first military medical facility ever designed specifically to use such a system, intended to enhance the command's ability to respond to the inevitable changes in health care delivery. The building also has a central computer that will monitor and control all critical systems—security, medical gases, and energy use within the hospital complex.

CAPT Rizzi places a silver dollar at the base of the hospital flagpole in the name of the Chief of Naval Operations.

For the safety of patients, staff, and visitors, the latest concepts in fire protection and detection systems will be provided. Additionally, closed circuit television surveillance equipment will monitor all sensitive areas of the complex. In the event of power failure, an emergency power distribution system on standby is designed to provide electrical service to all critical systems and equipment.

As we enter a new phase in the history of NRMC Camp Lejeune, we look optimistically to the future and the improvement in health services available to our Navy/Marine Corps family that this facility will make possible.

The planning and design for the new hospital was accomplished by the architectural and engineering joint venture of Lockwood-Greene/Six Associates, working with BUMED and the Atlantic Division of Naval Facilities Engineering Command. On 21 March 1979, a construction contract was awarded to Cardinal Contracting Company of Dallas, TX, for $39,339,000, with completion scheduled in late 1982 and occupancy in early 1983.

The new hospital is being built on a 162-acre site on Northeast Creek near the intersection of Stone Street and Brewster Boulevard and will contain approximately 420,000 square feet of floor space in the main hospital building, which includes the power plant and warehouse. This will be supplemented in 1983 by the construction of a Public Works support building, helo pad, and landscaping of the hospital site.

The hospital consists of a four-story nursing tower fronted by a two-story clinical and support building. The outpatient clinics have been efficiently designed to enhance staff productivity and permit easy access by patients to clinics and supporting services alike. Most significantly, the design is intended to segregate access to and circulation within the building, while guaranteeing future expansion. The basic structure is a cast-in-place, reinforced concrete frame of zero combustibility. The exterior walls are brick, masonry, and insulated glass. The interior finishes were selected for their durability, ease of maintenance, and aesthetic value.

The hospital will provide space for 205 inpatients, expandable to 236, plus extensive general and specialty care outpatient clinics. The inpatient spaces are designed in private, semiprivate, and four-bed units with private baths, to permit the mixing of patient categories within nursing units organized by medical specialty. This design allows for the maximum use of inpatient beds at all times, while providing a pleasant and dignified setting for the patient. The hospital is of ultra-modern design and uniquely color coordinated to encourage a warm and pleasant environment. The waterfront location on Northeast Creek will make maximum use of its natural wooded setting.

The hospital will provide space for 80 health care practitioners in suites consisting of an office and one or two exam rooms, depending on specialty. The Surgical Suite consists of five operating rooms, while the Obstetrical Suite has five labor rooms and three delivery rooms. The hospital will have modern, eight-bed Intensive and Coronary Care Units as well as a Neonatal Intensive Care Unit. A new Nuclear Medicine Service and expanded Laboratory and Radiology Services will give the hospital the latest diagnostic capabilities.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1982 - 361-323 - 128/206

PERSONNEL INSPECTION - 9 AUG 1982

REAR ADMIRAL SHEA, NC VISITS
9 AUGUST 1982

COMMODORE L. E. ANGELO, MSC, USN
RECEPTION MSC ANNIVERSARY

COMMODORE ANGELO'S VISIT -
14 AUGUST 1982

CAPTAIN STEIMEL'S RETIREMENT -
16 AUGUST 1982

CAPTAIN O'NEILL'S RETIREMENT AND
PERSONNEL INSPECTION - 18 OCT 82

PERSONNEL INSPECTION - 5 NOV 1982

USMC BIRTHDAY-GENERALS VISIT WARDS -
10 NOVEMBER 1982

USMC BIRTHDAY CAKE CUTTING AT NRMC
10 NOVEMBER 1982

BERNICE MIKEAL - LENGTH OF SERVICE
AWARD - 16 NOVEMBER 1982

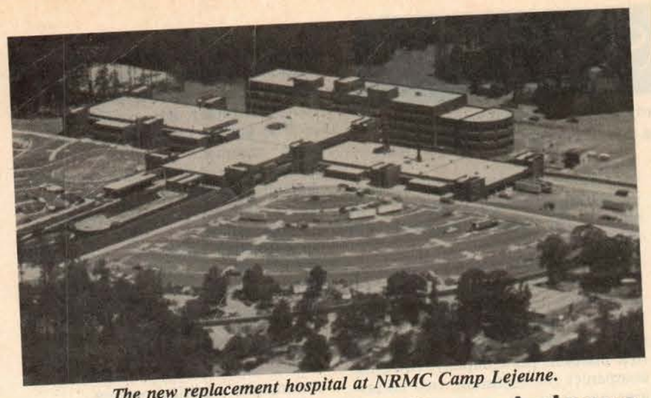
CLEVELAND WILLIAMS - LENGTH OF
SERVICE AWARD - 16 NOVEMBER 1982

LEWIS SMITH - LENGTH OF SERVICE
AWARD - 16 NOVEMBER 1982

RAYMOND COMBS - LENGTH OF SERVICE
AWARD - 16 NOVEMBER 1982

CLIFTON SPANGENBERG - LENGTH OF
SERVICE AWARD - 16 NOVEMBER 1982

TERITHA BATTS - LENGTH OF SERVICE
AWARD - 16 NOVEMBER 1982



The new replacement hospital at NRMC Camp Lejeune.

New Medical Center at Camp Lejeune

Camp Lejeune's naval regional medical center expects to take over part of its new $40 million hospital before 1 November and to complete its move from the old Hadnot Point hospital by mid-February 1983. Located on a 162-acre site near the intersection of Stone St. and Brewster Blvd., the new facility has been under construction since 1979.

The main building, with 420,000 square feet of floor space, will accommodate 205 inpatients (expandable to 236) and permit extensive general and specialty care through outpatient clinics. Space is available, in fact, for up to 80 health care practitioners in separate suites consisting of an office and 1 or 2 examining rooms. Medical center officials point out that the hospital design incorporates the latest, most modern concepts in hospital design. It will have a centralized computer, a centralized material management system, closed television surveillance systems, and expanded laboratory and radiology services. Its surgical suite will contain five operating rooms; the obstetrical suite, five labor rooms and three delivery rooms. There will be multiple intensive care units with specialized units for coronary and neonatal care.

The new hospital takes the place of the Hadnot Point hospital that was built in World War II and has provided care for Marines and their dependents over the past 40 years. Under current plans, Headquarters, 2d Marine Division will occupy the old hospital building and thus be able to consolidate its badly scattered staff sections and activities under one roof. Medical personnel, however, will continue to use the nearby quarters and barracks for billeting of personnel as such facilities have not yet been built near the new hospital.

Marine Corps Gazette † November 1982

CDR LACHAPELLE, MSC, USN
RETIREMENT CEREMONY - 7 DEC 1982

DINING OUT - 1982

MSC OFFICERS AND WIVES - 1982

Sgt. Tracy Bell

First of '83

Lieutenant Commander Randy Goodwin and his wife, Nancy, missed another deduction on their 1982 Federal Income Tax Return, when their son, Geoffrey Michael, was born on Jan. 1 at 4:46 a.m., making him the first baby of 1983 in the local area. The 8 pound, 20 ½ inch celebrity checked into the Naval Regional Medical Center and received a "Junior Seabag" from Navy Relief Society Layette Chairman, Marie Simons, which included diapers, blankets, sheets and other goodies. Geoffrey also received gifts from several local businesses for being the first of the year.

"CAMP LEJEUNE GLOBE" 6 January 1983

INSIDE

The new Naval Regional Medical Center is slated to open on Feb. 15. Navy Captain John Rizzi, commander of the facility, gives some insight to the benefits of the new hospital. Page 3

Opening soon

Captain John Rizzi, commander of the Naval Regional Medical Center, answers some questions about the opening of the new hospital and how it will help care for area Marines and sailors

by Sgt. Charles Brown
GLOBE Staff Reporter

The Naval Regional Medical Center will begin operating at the new facility located off Brewster Avenue on Feb. 15. Captain John Rizzi, commanding officer of the hospital, explained why the new facility was built and how it will benefit local military folks and their dependents.

"OVER THE YEARS the current hospital has changed its policy on outpatient treatment and has made it more flexible. By doing this we have had to change the way the hospital does business," the captain commented. "This has caused us to use the current building for many things it was not designed or built for. However, the new hospital was designed and built to serve patients more efficiently."

Capt. Rizzi said facilities in the old hospital are spread over a large area, but those in the new one will be centrally located for the benefit of patients.

Although the new hospital is smaller in terms of how many beds can be added during an emergency, Capt. Rizzi said that plans have been made to deal with that problem.

"THE DESIGN OF the hospital is one that can be expanded if need be, because other modules can readily be added by building additional decks in some areas and additional wings in others."

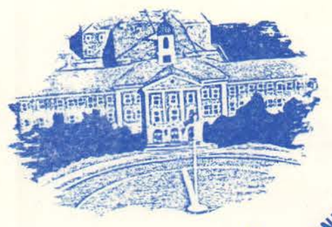
The captain said the staff of the new medical facility will increase about 12 percent, which works out to about 125 additional people. Patients can also expect to see a completely different type of atmosphere during their stay in the new medical center.

"What we have tried to do with the new hospital is, to make the patient feel right at home," remarked Capt. Rizzi. "We have accomplished this in several ways, first by placing a telephone and television in every room. The second is that all rooms will be for either two or three patients, which gives a lot more privacy to the patient than at the old hospital."

THE NEW HOSPITAL also has a surgical suite with five operating rooms, obstetrical suite with five labor rooms and three delivery rooms. Modern eight-bed Intensive and Coronary Care Units, as well as a Neonatal Intensive Care Unit have been built at the hospital. A new Nuclear Medicine Service and expanded Laboratory and Radiology Service will give the facility the latest diagnostic capabilities.

"I think the most unique part about the new hospital, however, is the Energy Monitor Computer," Capt. Rizzi said. "This system will monitor the air, temperatures, security sprinkler systems, ect. I guess it might be called the hospital's brain."

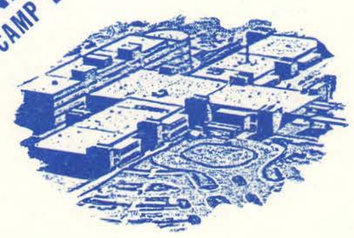
Capt. John Rizzi



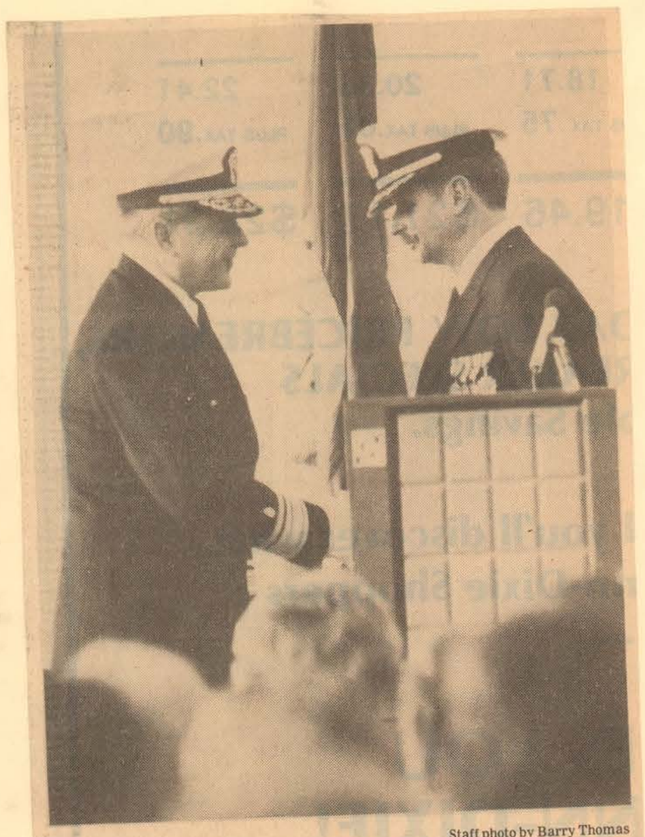
'83

TRANSITION
A CHANGE OF COMMAND
22 FEBRUARY, 1983

NAVAL REGIONAL MEDICAL CENTER
CAMP LEJEUNE, NORTH CAROLINA



CHANGE OF COMMAND - 22 FEBRUARY 1983



Staff photo by Barry Thomas

Welcome aboard

Navy Capt. John D. Marriott, right, is welcomed to his new assignment as commander of the Naval Regional Medical Center at Camp Lejeune by Rear Adm. James A. Zimble, Marine Corps naval medical officer in charge. Marriott, who replaces Capt. John N. Rizzi, completed undergraduate and medical school work at the University of North Carolina at Chapel Hill. The Battleboro native is married to the former Ellen Houston Joyner of Rocky Mount.

"JACKSONVILLE DAILY NEWS"
23 February 1983

CAPTAIN JOHN N. RIZZI, MC, USN

Outgoing Commanding Officer

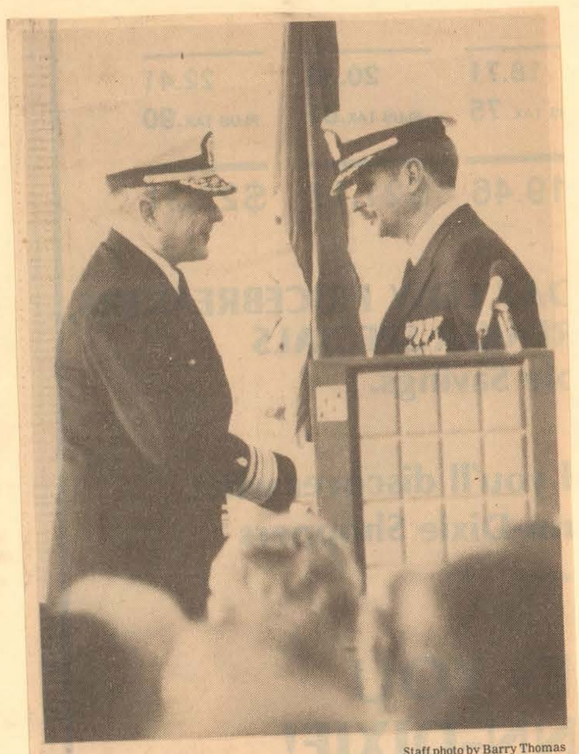
Captain John N. Rizzi, MC, U. S. Navy, was born on 18 January 1929 in Jamaica, New York. He received his Bachelor of Science Degree from Georgetown University, Washington, D. C., and was graduated from the New York Medical College in 1954. After interning at the Mary Immaculate Hospital and having served his residency in Obstetrics and Gynecology at the Queens General Hospital, both in Jamaica, New York, he came on active duty as one of the first "Berry" doctors. His first tour was at Naval Hospital, Newport, Rhode Island, followed by a short stint with DESLANT, and a tour at Naval Hospital, St. Albans, New York. He then entered private practice for several years but returned to active duty, and following a protracted tour at Naval Regional Medical Center, San Diego, he was ordered to the Bureau of Medicine and Surgery in 1977. While in Washington, Captain Rizzi served successively as Director of the Reserve Division, with additional duty to Recruiting Command; Special Assistant to the Surgeon General for Professional Affairs and Chief of Staff to the Surgeon General.

Captain Rizzi came to Camp Lejeune following two years as Director of Clinical Services at the Naval Regional Medical Center, Portsmouth, Virginia. He was promoted to his present rank on 2 June 1971 and holds the Meritorious Service Medal.

Captain Rizzi is a Diplomate of the American Board of Obstetrics and Gynecology; a Fellow of the American College of Obstetricians and Gynecologists; a Fellow of the American College of Surgeons; a member of the Royal Society of Medicine, a member of the Association of Military Surgeons of the United States, a member of the Society of Medical Consultants to the Armed Forces, and a member of the American Medical Association.

Captain Rizzi is married to the former Joyce Ann Tuerk and has two daughters.

CHANGE OF COMMAND - 22 FEBRUARY 1983



Staff photo by Barry Thomas

Welcome aboard

Navy Capt. John D. Marriott, right, is welcomed to his new assignment as commander of the Naval Regional Medical Center at Camp Lejeune by Rear Adm. James A. Zimble, Marine Corps naval medical officer in charge. Marriott, who replaces Capt. John N. Rizzi, completed undergraduate and medical school work at the University of North Carolina at Chapel Hill. The Battleboro native is married to the former Ellen Houston Joyner of Rocky Mount.

"JACKSONVILLE DAILY NEWS"
23 February 1983

The Chair

Navy's cost
$1,882

GSA price
$331

Reagan's chair
$1,400

The cost of an office

Item	Navy's cost	GSA price
Desk chair	$1,882	$331
Desk	845	760
2 credenzas	1,232	780
2-cushion sofa	765	750
3-cushion sofa	980	520
8-by-12 rug	1,192	166
5-by-9 rug	800	81
coffee table	662	106
lamp	114	25
end table	601	83
2 guest chairs	2,152	1,000
TOTAL	$11,225	$4,602

Savings lost by not using GSA.....$6,623

Lejeune hospital picked for Golden Fleece award

By J.L. PATE
Daily News Staff

WASHINGTON — Camp Lejeune's new Naval Regional Medical Center was singled out today by Sen. William Proxmire, D-Wis., for the dubious distinction of receiving his Golden Fleece award for the month of March.

Alerted by information he learned from the Jan. 28 edition of the Daily News, Proxmire chose to award the Navy Department his monthly Golden Fleece award "for spending $11,225 to decorate a Navy captain's office" at Lejeune's just-opened $49.8-million hospital.

Proxmire, a member of the Senate Appropriations Committee and the ranking Democrat on the Banking, Housing and Urban Affairs Committee, awards the Golden Fleece every month to what he considers to be the best example of "the most wasteful, ridiculous or ironic use of taxpayers' money."

"The commanding officer at the Naval Regional Medical Center in Jacksonville, N.C., sits in a $1,882 chair, a chair that cost $500 more than the chair President Reagan sits in at cabinet meetings," Proxmire said in a prepared statement.

"Two Oriental-motif rugs, which cost almost $2,000, soften footsteps in the captain's office (which has a hardwood herringbone-parquet floor) and visitors make themselves comfortable in (two) $1,000 guest chairs," Proxmire said. "This is one commanding officer who sits pretty while the taxpayers are sitting on lighter pockets."

Navy officials at Camp Lejeune and in Washington have defended the choice of furniture for the office of the hospital's commanding officer, saying that no Navy officials, including recently departed Capt. John N. Rizzi, who now commands a Navy hospital in Virginia, had anything to do with the selection.

Rizzi was replaced as head of Camp Lejeune's 205-bed hospital in a Feb. 22 ceremony by Capt. John D. Marriott, a native of Battleboro.

Although General Services Administration records indicate the Lejeune hospital commander's chair cost $500 more than the commander-in-chief's cabinet room chair, Navy Cmdr. Edward Phillips defended the cost of the NRMC captain's desk seat during a guided tour of the new hospital, saying that "this is a typical executive's chair for an office at this level (of responsibility)."

In addition to furnishings in the captain's office, the Navy spent another $2,308 for two more Oriental-motif rugs for an office just adjacent to that of the hospital commander. It also spent almost $55,000 to build a rock garden display in the lobby.

During the February tour, Phillips also backed those purchases. "Naturally, a lot of the folks who come here don't feel well," he said. "The intent of the rock garden is to provide a restful green area for patients. Architects tell us people respond to these types of things."

Nevertheless, such a purchase for aesthetic purposes would not be allowed for a civilian hospital seeking government aid, according to Conrad Taylor, chief of the construction section of state Division of Facilities Services, the agency that must approve plans for all non-military hospitals in the state receiving taxpayer support.

"If someone had brought us plans for something like that, we'd have told them to go somewhere else and get their money," Taylor said in a telephone interview late Tuesday.

Officials at the GSA, the agency charged with procurement of such items as furniture for most federal government offices, indicated the Navy Department spent almost one-and-a-half times as much as the GSA would have had it been allowed to provide furnishings for the commanding officer's office at the new Lejeune hospital.

Using what they described as top-of-the-line furnishings, GSA officials said they would have provided the same items for $4,602. The GSA furnishings consequently would have cost $6,602 less — or less than half — than the $11,225 the Navy Department actually spent.

In denying any responsibility for the type of furnishings installed in the hospital commander's office, Navy Department spokesmen at Camp Lejeune and in Washington said the acquisitions were the responsibility of Lockwood-Greene/ Six Associates, Inc., architects, engineers and planners for the hospital project.

Navy officials in Washington, however, later conceded that the Six Associates furniture selections had to be approved and funded by the Naval Supply Center in Norfolk, Va.

"JACKSONVILLE DAILY NEWS" 16 March 1983 (Front Page)

Civilian Guidepost

Compiled and Edited by

CIVILIAN PERSONNEL DIVISION, MARINE CORPS BASE, CAMP LEJEUNE, NORTH CAROLINA

Issuance of this periodical approved in accordance with Department of the Navy Publications and Printing Regulations

VOLUME 28 NO. 6 25 March 1983

NAVAL REGIONAL MEDICAL CENTER
CHANGE OF COMMAND

At the change of command program on 22 February 1983, Captain John D. Marriott, MC, USN, Commanding Officer of the Naval Regional Medical Center closed his remarks with the following poem by Ella Wheeler Wilcox. It is deserving of reprint here and especially for personnel of the Naval Regional Medical Center who could not be released from their jobs to attend the program.

WILL

One ship sails east, and another west
With the self-same winds that blow,
'Tis the set of the sails
And not the gales,
Which decides which way to go.

Like the winds of the sea are the ways of fate;
As the voyage along through life;
'Tis the will of the soul
That decides its goal,
And not the calm or the strife.

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Medical center's head always liked medicine

By J.L. PATE
Daily News Staff

Little more than 100 miles separates the Nash County farming hamlet of Battleboro from Jacksonville, but for John Daughtry Marriott, the trip has taken thousands of miles and two decades.

On Feb. 22, only 10 days after his 46th birthday, the Navy captain assumed command of Camp Lejeune's brand new $49-million Naval Regional Medical Center.

The Tar Heel native entered the Navy in 1962, while he was a senior at the University of North Carolina Medical School in Chapel Hill, where he had also completed his undergraduate work.

But it was not until October 1982, when he received orders to become the director of clinical services at Camp Lejeune's old Naval Regional Medical Center, that Marriott was finally able to return to his home state.

He was not sure where the Navy would eventually take him or even if he would make it a life's career, but there was never any doubt about what professional path he would always follow in life: medicine.

Marriott's father, although the family lived in the small town just north of Rocky Mount, was a farmer, a bond with ancestral land shared by John's older brother. So Marriott decided he should do something else and for his decision, he looked deeper into his family roots.

Back in the horse-and-buggy days, when bedside manner was an essential quality for doctors who still made house calls to treat the ill and infirm, delivering babies in stately country great-grandfather were doctors.

"As long as I can remember, I wanted to be a doctor," Marriott confided in a Thursday interview. "I didn't want to be a farmer or a policeman or a fireman, the many stages young boys often go through. I never really wanted to be anything else but a doctor."

His parents from his earliest years supported this wish and when Marriott reached the seventh grade, they paid a tuition so he could leave the small country school where there was one teacher for every two grades and attend classes at Rocky Mount, where he graduated in 1954.

It was pre-med all the way during his four undergraduate years at UNC, work that paid off when he was admitted as a medical student in Chapel Hill in 1958.

As tough as his undergraduate years were, they were interspersed with restful visits home to Battleboro, where the spring, summer and fall dances were a local attraction everyone always looked forward to, featuring such acts as Les Brown and Stan Kenton.

It was at one of these dances when he was a college freshman that Marriott encountered the only distraction that would exceed his obsession with becoming a doctor.

A UNC fraternity brother from nearby Nashville agreed to set Marriott up with a blind date from Rocky Mount. Thus did Marriott come to know and love Ellen Houston Joyner, his future wife.

"I sort of knew who she was at the time," Marriott said Thursday, "but I manors and ramshackle tenant houses, Marriott's grandfather and didn't really know her."

Did they hit it off?

"I never really dated anybody else after that," he said, adding that they were married his sophomore year in medical school.

As a means of easing the financial burden born by his parents during his years in Chapel Hill, Marriott signed up for the Navy's Ensign 1915 Program when he was a senior medical student in 1962.

"It paid you ensign's pay during your senior year of med school and obligated you to two years of service," he explained in his softspoken easy-going manner that, despite all the dressings of a senior Naval medical officer, has not lost its down-home, farm-boy charm.

Then, with a sly smile, he acknowledged, "I figured I'd do my time and get out."

But after a residency at the University of Florida and two years of duty at a recruiting station in New Orleans, Marriott decided the Navy might deserve more consideration.

That led to a residency in radiology beginning in 1965 at the Naval Hospital in San Diego, a time when nuclear medicine was in its infancy and the demand for skilled physicians in the military and civilian sectors was tremendous. Following two years of training in what is now his specialty, Marriott served for a year as chief of radiology aboard the hospital ship USS Sanctuary off the coast of Vietnam.

In 1970, he returned to San Diego's Naval Regional Medical Center, where he was assigned as staff radiologist and head of nuclear medicine. From 1974 until coming to Lejeune in 1982, Marriott was chief of radiology at the Portsmouth, Va., NRMC, and for the past five years has also served as Specialty Consultant for Radiology to the Navy Surgeon General.

Staff photo by Barry Thomas

Marriott

The Marriotts now have three children, John Jr., who recently graduated from UNC-CH, and Elizabeth and Ellen, who are students at the University of North Carolina at Wilmington.

Marriott said he has "a lot of ideas" to bring to his new post and acknowledged that he has already received a large volume of letters — both good and bad — from NRMC patients.

"I think access to the system is more of a problem than the actual quality of care," Marriott said. "There are times when our people are a little bit harried and many patients, of course, don't feel so good, so flare-ups do occur."

Two problems he mentioned concerning patient access to the NRMC system, he said, concern the new telephone system, "a fairly sophisticated system" that is still undergoing fine tuning, and scheduling appointments in the outpatient clinics.

The telephone system problem is being approached on a long-term basis with a base-wide renovation and improving of trunk lines coming into Camp Lejeune set for this fall, he said. But in the meantime, Carolina Telephone will be helping provide a short-term cure within the next three weeks by installing 15 extra telephone lines to the hospital, where a full-time switchboard operator will handle calls.

As for scheduling appointments in the NRMC's various clinics, the old centralized system will be discontinued soon in favor of a decentralized method by which potential patients will call the specific clinic they need to visit.

"The old system," Marriott acknowledged, "did not allow enough flexibility for the stacking of patient appointments and assigning priority to various needs. It was too much on a first-come, first-served basis."

It is hardly news that not only at Lejeune's NRMC, but throughout the Navy, medical teams are understaffed and overworked, but Marriott said he wants to emphasize the same type of medical treatment one got in the days when his grandfather and great-grandfather would pull up in a buggy to a patient's house: "Concerned, courteous, compassionate care."

"JACKSONVILLE DAILY NEWS" 26 March 1983

Navy Nurse Corps marks anniversary

Nurses at Camp Lejeune plan May 13 celebration

by LCpl. Pamela Vajner

Nine years before pioneer nurse Florence Nightingale was born, a young surgeon was commissioned by the Secretary of the Navy to recommend the care America's military sick and wounded might need. That was the year before the fledging nation became involved in the war of 1812.

NEARLY 100 YEARS later his recommendations, including creation of a cadre of professional Navy nurses, were adopted. This year on May 13, the U. S. Navy Nurse corps marks the 75th anniversary of that founding. Today there are some 2,600 professional nurses in the Navy who help care for sailors and Marines. Over the years--in war and peace--Navy nurses have developed a proud tradition of professional health care.

Within months after the Navy Nurse Corps was established in 1908, the first group of nurses, dubbed the "Sacred Twenty," reported for duty. In one year, enlistments more than doubled. By 1910, Navy nurses were serving in the Philippines, Guam, Samoa, and Cuba. By the end of the first World War, the total Navy nurse strength was 1,386.

As the only women in the Navy at the time, nurses were unique. They were designated as neither officer nor enlisted and were given only quasi-military status. That ended when the attacks on Pearl Harbor plunged America into World War II.

IN THAT BLOODY conflict, five nurses were captured by the Japanese on Guam and 11 were taken prisoner in the Philippines. All survived as POWs and passed the time caring for the sick and wounded in enemy prison camps.

The status of nurses in the Navy changed dramatically at the beginning of the Korean conflict. Three hospital corps schools opened, two hospital ships and eight Military Sea Transport Service ships were commissioned. Many included Navy nurses on their staffs.

There were 1,950 regular and reserve Nurse Corps officers on active duty assigned in and out of the continental United States to 26 naval hospitals and 67 station hospitals and dispensaries in the 1950's.

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Navy nurse LT Lydia Companion comforts a younster at NRMC

tinental United States to 26 naval hospitals and 67 station hospitals and dispensaries in the 1950's.

WITH THE OUTBREAK of fighting in Vietnam in the mid-1960s, Navy nurses were called into action again, many serving in Danang, Saigon, and aboard the hospital ships USS Repose and USS Sanctuary. In 1965, the first man was commissioned as a Navy nurse, altering the standards originally set for nurses.

Those were established by Dr. William P. Barton, the Navy's first Chief of Medicine and Surgery, who decreed that nurses "should be women of humane disposition and tender manners...who attend with fidelity and care upon all the sick committed to their charge."

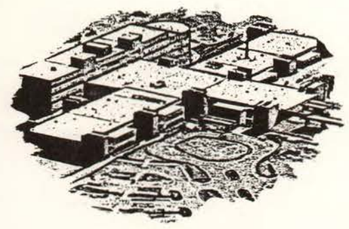
While the necessary characteristics haven't changed, it became obvious to the Navy's Bureau of Medicine that men as well as women possessed them in modern society. Currently male and female Navy nurses train and serve in hospitals around the world, including here at Camp Lejeune's Naval Regional Medical Center.

ACCORDING TO NAVY Captain Claudette Clunan, Director of Nursing Services here, the 81 male nurses currently on active duty work with doctors and corpsmen in all medical fields to complete the health care team. They also participate in special operations that are barred to women who are not allowed aboard combat ships or in certain forward areas, according to Capt. Clunan.

As an example, male nurses from Camp Lejeune participated in cold weather combat training in Norway this year.

To celebrate the history of the Corps' accomplishments, local Navy nurses have scheduled a cake-cutting ceremony for all hospital staff the afternoon of May 13. Also planned is a formal dinner celebration at the Commissioned Officers Club at the New River Air Station.

DEDICATION CEREMONY

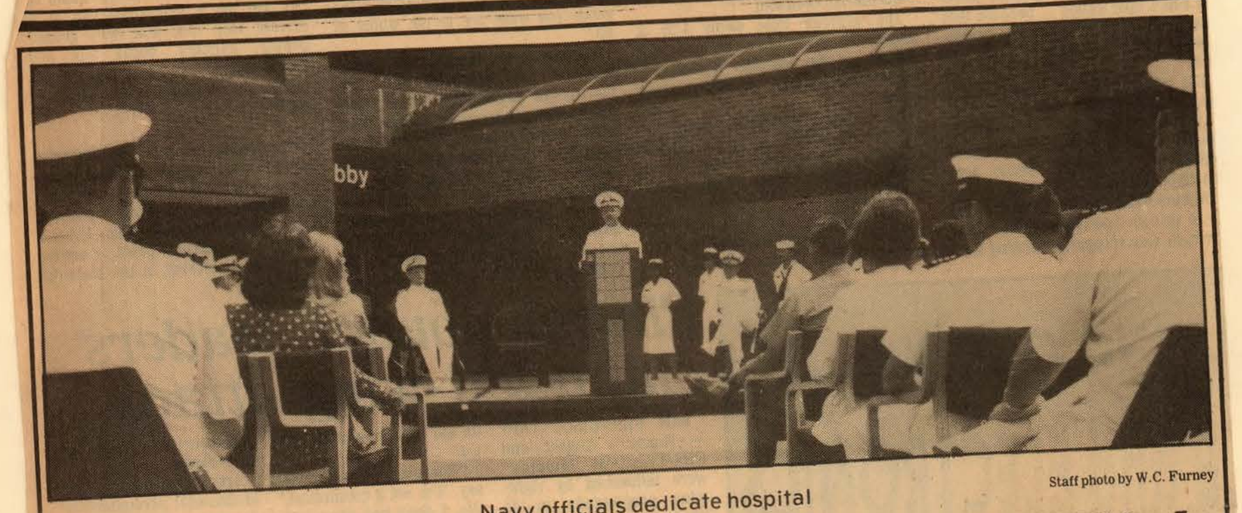


NEW CENTER HOSPITAL
naval regional medical center
camp lejeune, north carolina

THURSDAY, 12 MAY 1983

B Daily News Friday, May 13, 1983

Local



Staff photo by W.C. Furney

Navy officials dedicate hospital

Surgeon general praises new hospital

By W.C. FURNEY
Daily News Staff

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Calling it the best of several new military medical installations, Cox gave the new facility a high rating.

"Based on life experiences on a rating from one to ten — this must be a ten," Cox said. "We have only completed what others before us began. I am glad that I could be here to see the fruit of their labor."

It was not the Navy Cox heralded, however, but the Marine Corps.

"The vast majority of effort has come from them," he said. "What we do in the future will be on behalf of the magnificent personnel of the U.S. Marine Corps."

Comparing the medical corps job to that of civilian doctors, Cox said there are several differences.

"We in the military medical corps must not only simultaneously perform medicine, but we must train willingly and be able to exercise skill anywhere in the world — at any time."

To show the importance of the medical corps in the overall military scheme of things, Cox used the analogy of a fighting dragon.

"We are not the tail of the fighting dragon," he said. "And we are not the teeth. We are the gums that hold the teeth."

But even while standing at the base of the new medical building, Cox expressed concern about the future.

"The old facility will remain intact for future use in case of war or any need of emergency expansion," he said. "We can virtually open a 500-bed facility overnight."

Concluding his speach, Cox said he is also concerned about the care of military dependents and maintaining the skills of military medical staff.

"Some people say it is a liability, but I say it is an asset," he said. "Dependent care is not a nice-to-do, it is a must-to-do. If we don't maintain our skills in peacetime, we won't be able to do them in wartime."

The dedication ceremony marked an end to the facility's inauspicious beginning. In March, the medical center was awarded Sen. William Proxmire's dubious Golden Fleece award because of an $1,880 chair in the commanding officer's office.

Trying to forget this episode, Navy officials are calling the new hospital one of the best by service officials.

The construction of the hospital began in May 1979 and is "designed to reflect the most progressive thinking in medicine today," according to military spokesmen.

Part of this thinking is the facility's floor plan, its computer-controlled electrical, heating, cooling and fire system, its extensive use of interchangeable, modular office equipment and its centralized material management center featuring a modular material handling and casework system.

This last feature is described as a system that utilizes moveable cabinets hanging from wall brackets throughout the hospital.

When one cabinet is empty, personnel take it off the bracket and replace it with a full one. The empty cabinet is returned to the supply area where it is replenished for use again.

Placing greater emphasis on outpatient care, the new hospital only has a 205-bed capacity, although it can be expanded to 236 beds.

The internal layout is designed for patient and staff efficiency. There are separate hallways for hospital personnel and patients. The emergency room, X-ray department, surgical suites and intensive care unit adjoin each other on the same floor to minimize lost time in treating the critically injured.

The new medical center also features five operating rooms, three delivery rooms, five labor rooms and 100 examination rooms.

CDR SLOAS FROCKED TO CDR - 5/26/83

CDR TULURI - FROCKED TO CDR - 26 MAY 1983

4 Globe,
May 5, 1983

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*Navy nurse LT Lydia Compan
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Dedication Ceremony

Music.....2D Marine Division Band

INVOCATION
Lieutenant Robert E. Fritts, Jr., CHC, U. S. Naval Reserve
Assistant Chief, Pastoral Care Services

INTRODUCTION OF COMMANDING OFFICER
Lieutenant David A. Wynkoop, MSC, U. S. Navy
Medical Construction Liaison Officer

WELCOMING REMARKS AND INTRODUCTION OF DISTINGUISHED GUESTS
Captain J. D. Marriott, MC, U. S. Navy
Commanding Officer

DELIVERY OF NEW BUILDING TO CARDINAL CONTRACTING COMPANY
Mr. Otis C. Jones
Senior Vice President, Lockwood Greene/Six Associates

TRANSFER OF NEW BUILDING TO NAVAL FACILITIES ENGINEERING COMMAND
Mr. Kenneth Merrill
Executive Vice President, Cardinal Contracting Company

TRANSFER OF NEW BUILDING TO NAVAL MEDICAL COMMAND
Commodore John C. Fraser, Jr., CEC, U. S. Navy
Deputy Commander for Planning
Naval Facilities Engineering Command

TRANSFER OF NEW BUILDING TO COMMANDING OFFICER
Rear Admiral Norman V. Cooley, Jr., MC, U. S. Navy
Commander, Naval Medical Command, Mid-Atlantic Region

ACCEPTANCE OF NEW BUILDING
Captain J. D. Marriott, MC, U. S. Navy

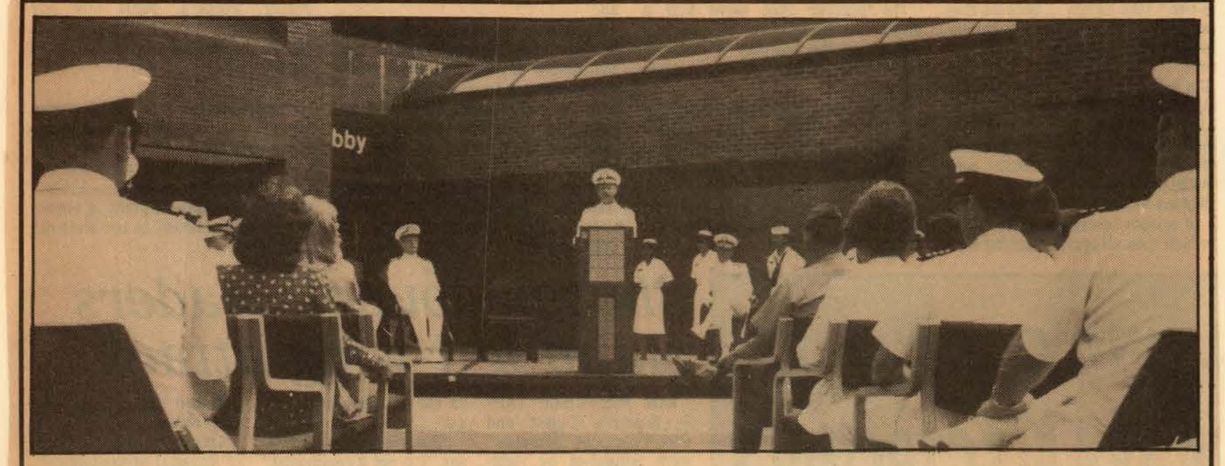
DEDICATORY ADDRESS
Vice Admiral J. William Cox, MC, U. S. Navy
Surgeon General of the Navy

BENEDICTION AND DEDICATION PRAYER
Commander James C. Clift, CHC, U. S. Naval Reserve

RECEPTION AND OPEN HOUSE
Guests are cordially invited to join
the Commanding Officer and Staff

B Daily News
Friday, May 13, 1983

Local



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THE NEW CENTER HOSPITAL

THE PLANNING AND DESIGN FOR THE NEW HOSPITAL WAS ACCOMPLISHED BY THE ARCHITECTURAL AND ENGINEERING JOINT VENTURE OF LOCKWOOD-GREENE/SIX ASSOCIATES, WORKING WITH THE BUREAU OF MEDICINE AND SURGERY AND ATLANTIC DIVISION OF NAVAL FACILITIES ENGINEERING COMMAND. THE CONSTRUCTION CONTACT WAS AWARDED TO CARDINAL CONTRACTING COMPANY OF DALLAS, TEXAS. ON MARCH 21, 1979. THE PROJECT WAS COMPLETED IN LATE 1982 AND A SUCCESSFUL MOVE IN WAS ACCOMPLISHED ON FEBURARY 12, 1983.

THE NEW HOSPITAL IS BUILT ON A 162 ACRE SITE ON NORTHEAST CREEK NEAR THE INTERSECTION OF STONE STREET AND BREWSTER BOULEVARD. THE FACILITY CONTAINS APPROXIMATELY 420,000 SQUARE FEET OF FLOOR SPACE IN THE MAIN HOSPITAL BUILDING, WHICH INCLUDES THE POWER PLANT AND WAREHOUSE. THIS WILL BE SUPPLEMENTED LATER IN 1983 BY THE CONSTRUCTION OF A PUBLIC WORKS SUPPORT BUILDING AND HELO PAD.

THE HOSPITAL CONSISTS OF A FOUR-STORY NURSING TOWER FRONTED BY A TWO-STORY CLINICAL AND SUPPORT BUILDING. THE OUTPATIENT CLINICS HAVE BEEN EFFICIENTLY DESIGNED TO ENHANCE STAFF PRODUCTIVITY AND PERMIT EASY ACCESS BY PATIENTS TO CLINICS AND SUPPORTING SERVICES ALIKE. MOST SIGNIFICANTLY THE DESIGN IS INTENDED TO SEGREGATE ACCESS TO AND CIRCULATION WITHIN THE BUILDING, WHILE GUARANTEEING FUTURE EXPANSION. THE BASIC STRUCTURE IS A CAST-IN-PLACE, REINFORCED CONCRETE FRAME OF ZERO COMBUSTIBILITY. THE EXTERIOR WALLS ARE BRICK MASONRY AND INSULATED GLASS. THE INTERIOR FINISHES WERE SELECTED FOR THEIR DURABILITY, EASE OF MAINTENANCE AND AESTHETIC VALUE.

THE HOSPITAL PROVIDES SPACE FOR 205 INPATIENTS, EXPANDABLE TO 236, PLUS EXTENSIVE GENERAL AND SPECIALTY CARE OUTPATIENT CLINICS. THE INPATIENT SPACES ARE DESIGNED IN PRIVATE, SEMI-PRIVATE, AND FOUR BED UNITS WITH PRIVATE BATHS, TO PERMIT THE MIXING OF PATIENT CATEGORIES WITHIN NURSING UNITS ORGANIZED BY MEDICAL SPECIALTY. THIS DESIGN ALLOWS FOR MAXIMUM UTILIZATION OF INPATIENT BEDS AT ALL TIMES, WHILE PROVIDING A PLEASANT AND DIGNIFIED SETTING FOR THE PATIENT. THE HOSPITAL IS OF ULTRA-MODERN DESIGN AND UNIQUELY COLOR COORDINATED TO ENCOURAGE A WARM AND PLEASANT ENVIRONMENT. THE WATERFRONT LOCATION ON NORTHEAST CREEK MAKES MAXIMUM USE OF ITS NATURAL WOODED SETTING.

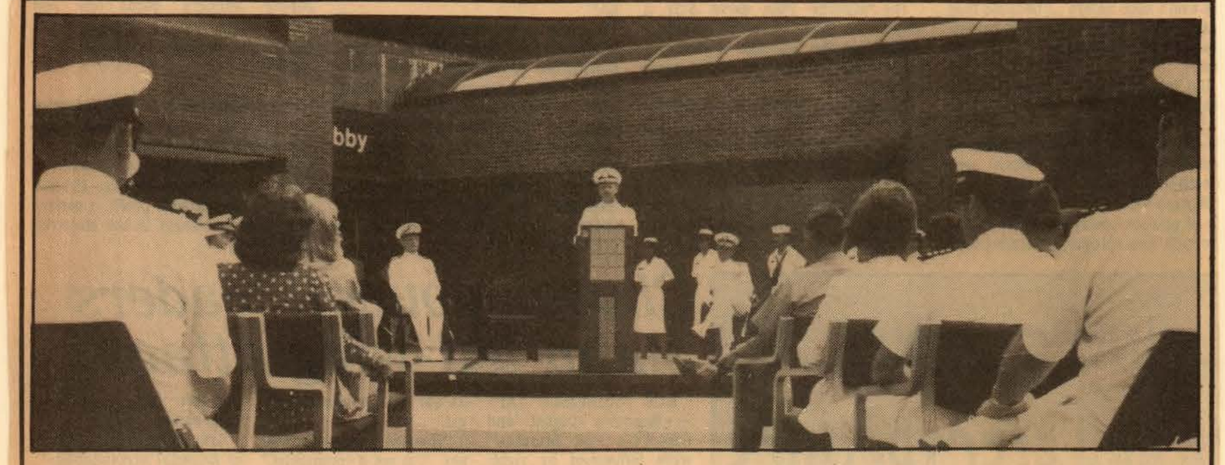
THE HOSPITAL PROVIDES SPACE FOR 80 HEALTH CARE PRACTITIONERS IN SUITES CONSISTING OF AN OFFICE AND ONE OR TWO EXAM ROOMS, DEPENDING ON SPECIALTY. THE SURGICAL SUITE CONSISTS OF FIVE OPERATING ROOMS, WHILE THE OBSTETRICAL SUITE HAS FIVE LABOR ROOMS AND THREE DELIVERY ROOMS. THE HOSPITAL HAS A MODERN EIGHT BED INTENSIVE CARE UNIT AND EIGHT BED CORONARY CARE UNIT, AS WELL AS A NEONTAL INTENSIVE CARE UNIT. A NEW NUCLEAR MEDICINE SERVICE AND EXPANDED LABORATORY AND RADIOLOGY SERVICES GIVE THE HOSPITAL THE LATEST DIAGNOSTIC CAPABILITIES.

THE DESIGN OF THE FACILITY INCORPORATES THE MOST MODERN CONCEPTS IN HOSPITAL OPERATIONS, INCLUDING THE CENTRALIZED MATERIAL MANAGEMENT CENTER BASED ON A MODULAR MATERIAL HANDLING AND CASEWORK SYSTEM THAT WILL PROVIDE DAILY DELIVERY OF ALL MEDICAL SURGICAL SUPPLIES AND LINEN REQUIRED TO OPERATE THE HOSPITAL. CAMP LEJEUNE IS THE FIRST MILITARY MEDICAL FACILITY EVER DESIGNED SPECIFICALLY TO UTILIZE SUCH A SYSTEM. THIS SYSTEM IS INTENDED TO ENCHANCE THE COMMAND'S ABILITY TO RESPOND TO THE INEVITABLE AND ONGOING CHANGES IN HEALTH CARE DELIVERY. THE BUILDING ALSO HAS A CENTRAL COMPUTER THAT WILL MONITOR AND CONTROL ALL CRITICAL SYSTEMS FROM SECURITY TO MEDICAL GASES, TO THE UTILIZATION OF ENERGY WITHIN THE HOSPITAL COMPLEX.

FOR THE SAFETY OF OUR PATIENTS, STAFF, AND VISITORS, THE LATEST CONCEPTS IN FIRE PROTECTION AND DETECTION SYSTEMS ARE PROVIDED. ADDITIONALLY, CLOSED CIRCUIT TELEVISION SURVEILLANCE EQUIPMENT MONITORS ALL SENSITIVE AREAS OF THE COMPLEX. IN THE EVENT OF A POWER FAILURE, AN EMERGENCY POWER DISTRIBUTION SYSTEM IS ON STANDBY TO PROVIDE ELECTRICAL SERVICE TO ALL CRITICAL SYSTEMS AND EQUIPMENT.

AS WE ENTER A NEW PHASE IN THE HISTORY OF THE NAVAL REGIONAL MEDICAL CENTER, CAMP LEJEUNE, WE LOOK OPTIMISTICALLY TO THE FUTURE AND THE IMPROVEMENT IN HEALTH SERVICES AVAILABLE TO OUR NAVY/MARINE CORPS FAMILY THAT THIS FACILITY WILL MAKE POSSIBLE.

B Daily News Friday, May 13, 1983 Local



Navy officials dedicate hospital — Staff photo by W.C. Furney

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ARCHITECT'S RENDERING

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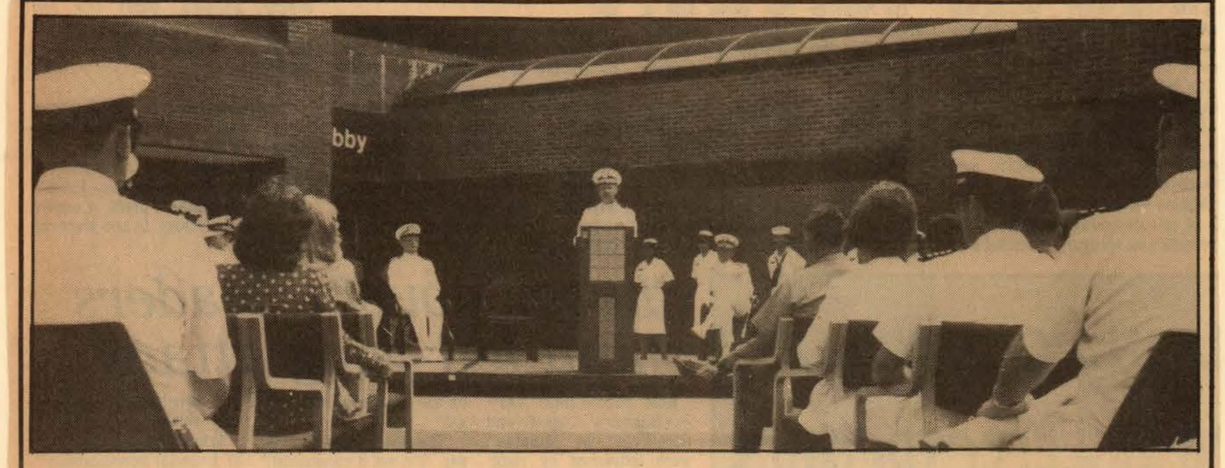

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PICTURES

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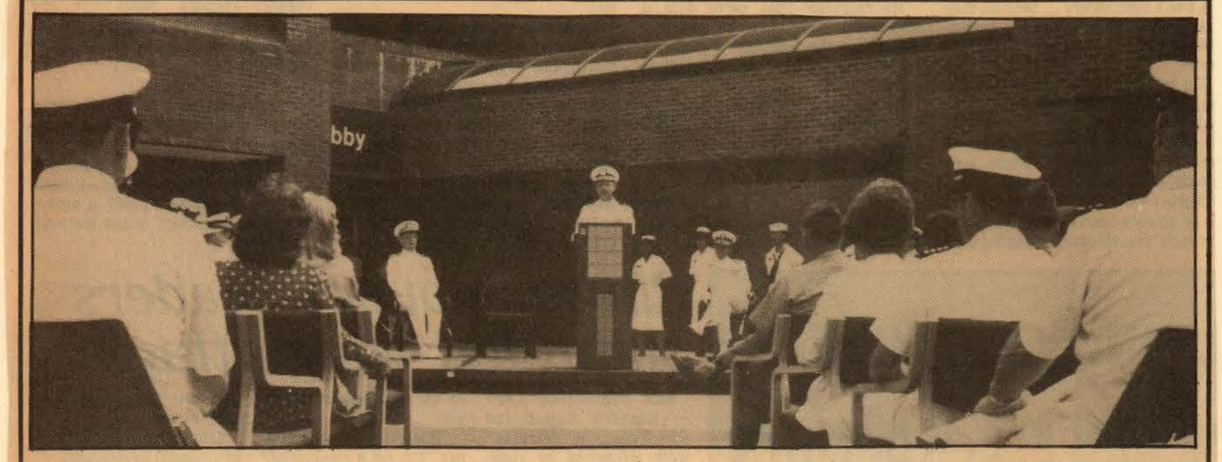

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NEARING COMPLETION - JUNE 1982

AERIAL VIEW OF COMPLETED FACILITY - OCTOBER 1982

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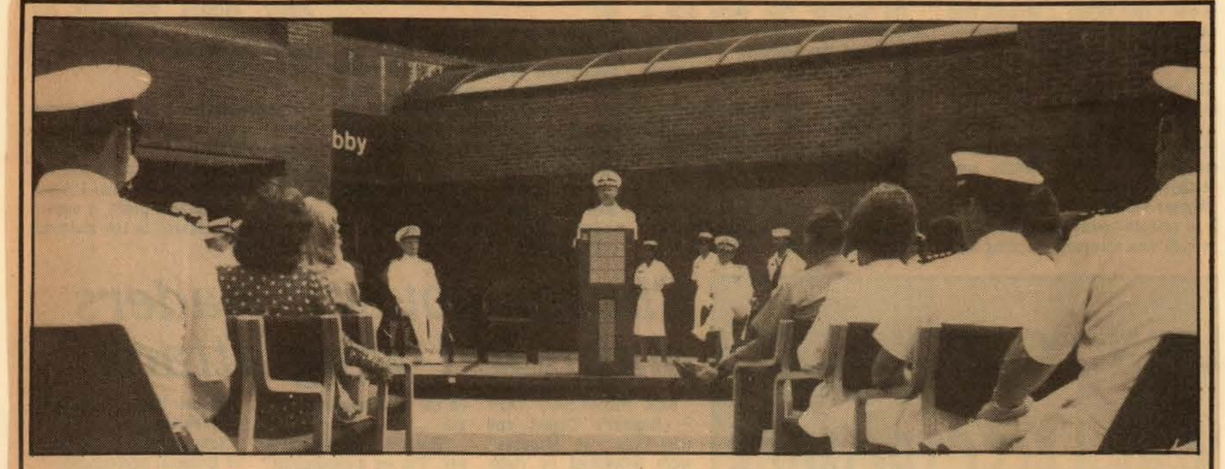

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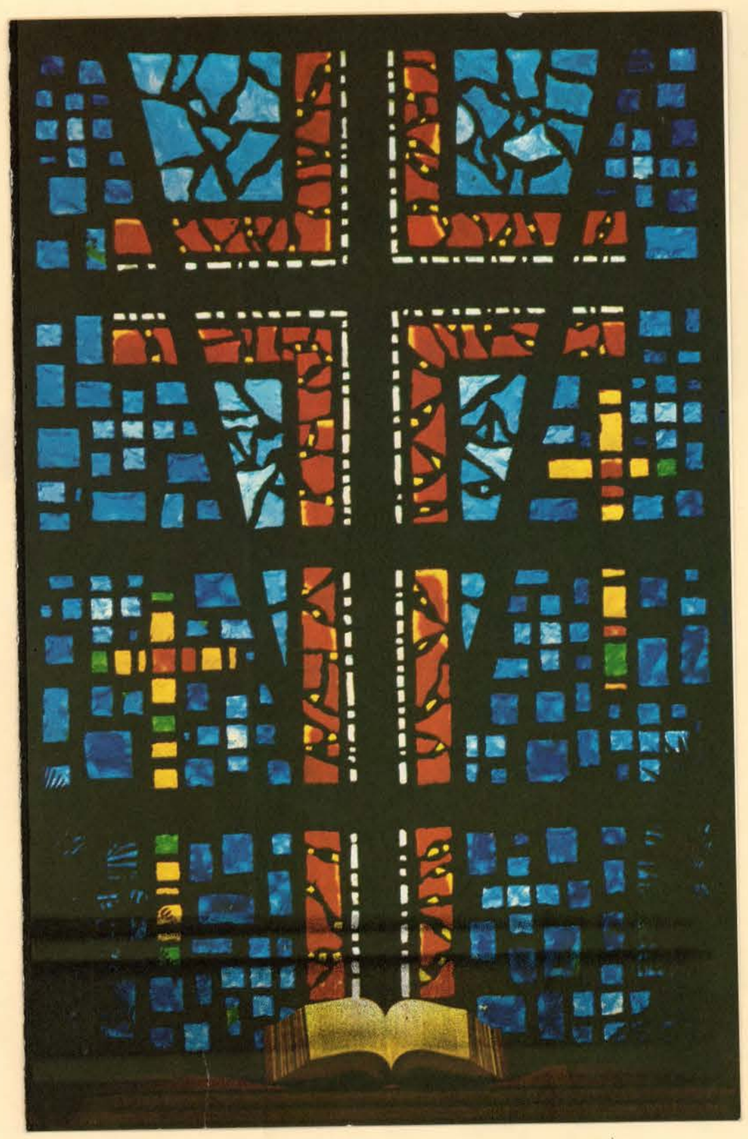


Camp Lejeune's New Hospital

Story and photos by P. L. Thompson

Located on a 162-acre site, the new medical facility is expected to handle more than 8,000 admissions a year and more than 540,000 outpatient visits.

Marine Corps Base, Camp Lejeune, N.C., is now the home of an ultra-modern, $45.3 million Naval Regional Medical Facility, offering treatment and services to the military community of the base and the surrounding area.

The 205-bed hospital, with its extensive outpatient facilities, is located on a sprawling 162-acre site near the intersection of Stone Street and Brewster Boulevard at Camp Lejeune.

Navy Lt David A. Wynkoop, the Medical Construction Liaison Officer, is proud of the new facility. "The contract for the hospital was brought in on time and on budget and we accomplished the move from our old hospital to the new one in a little less than five days," he said.

"We opened our doors for business the morning of Tuesday, February 15, 1983. In fact, the first baby was born in one of our three delivery rooms on the Saturday before we were officially open," Wynkoop pointed out.

The new medical facility will offer many advanced features for the comfort, treatment and care of patients.

"We now offer private and semi-private rooms, or those with four beds, depending on the needs of the patients. The hospital has 205 beds, but it can be expanded to accept 236 if the need should arise.

"The new facility features an Energy Monitoring and Control System (EMCS), which is the largest and most extensive computer-based distributive process building control system ever installed in a Naval shore facility," related Wynkoop. The EMCS can transfer heat or air-conditioning from one part of the building to where it is needed the most, maintaining a constant and comfortable temperature," he added.

The EMCS is programmed to know that the outpatient facility closes at a certain hour. At the proper time, the computer will shut down the heat and lights to that part of the building and warm it up again the next morning.

The computer is also used for security purposes and it has a complete communications system which enables it to play background music in the public areas of the hospital.

"Most importantly, the computer also handles our fire alarm system. It has the ability, when smoke is detected, to create a negative air pressure within the building that prevents the fire from spreading," said Wynkoop.

Although initially expensive, the EMCS system was designed to handle its different functions as a cost-saving factor. Lt Wynkoop believes the system will pay for itself in energy savings alone.

Another unique feature of the new hospital's design is the regulation of traffic flow within the building.

"One of the problems we had with the old hospital was moving our staff through areas that contained a large

Civilian Guidepost

Compiled and Edited by

CIVILIAN PERSONNEL DIVISION, MARINE CORPS BASE, CAMP LEJEUNE, NORTH CAROLINA

Issuance of this periodical approved in accordance with Department of the Navy Publications and Printing Regulations

VOLUME 28 NO. 12. 17 June 1983

BENEFICIAL SUGGESTION WINNER

Captain J. D. Marriott, MC, USN, Commanding Officer, Naval Regional Medical Center, recently presented a Beneficial Suggestion award to Mrs. Mary F. Garner. Mrs. Garner received a cash award of $300 for her suggestion to revise the Navy Performance Appraisal Form NAVSO 12430/9 so that all information would fit on one 8½" x 11" page with Performance Standards attached to that page, eliminating additional typing of the standards. The award was based on moderate first year savings with a broad extent of application.

Mrs. Garner was given a "Beneficial Suggestion Winner" coffee mug in addition to her certificate and check.

If you too would like to be a "Beneficial Suggestion Winner," submit a Beneficial Suggestion today! If you need a suggestion form, ask your supervisor or call extension 1458 or 1579.

CDR HAYNES - FROCKED TO CDR -
26 MAY 1983

NAVAL HOSPITAL
CAMP LEJEUNE, NC
1100 8 JUNE 1983

MEMORIAL SERVICE FOR HN HERMAN LEE BROWN, USN

HYMN (The Lord's Prayer).....Edith Harris

OPENING PRAYER.....Chaplain Clift

SCRIPTURE READING (Book of Wisdom) HM2 Cichowicz, USN

PSALM 23

The Lord is my shepherd; I shall not want.
In verdant pastures he gives me repose;
Beside restful waters he leads me;
he refreshes my soul.
He guides me in right paths for his name's sake.
Even though I walk in the dark valley I fear no evil;
for you are at my side with your rod and your staff
that give me courage.
You spread the table before me in the sight of my foes;
you annoint my head with oil; my cup overflows.
Only goodness and kindness follow me all the days of my life;
and I shall dwell in the house of the Lord for years to come.

SCRIPTURE READING (1 JN 4:7-21).....Pat Trexler

EULOGY.....Chaplain Clift

BENEDICTION.....Chaplain Clift

NAVY HYMN [PLEASE SEE BACK COVER]

PIPING ASIDE.....BM2 Willis

HERMAN LEE BROWN
HOSPITALMAN
UNITED STATES NAVY

BORN
18 NOVEMBER 1953

DIED
1 JUNE 1983

HOSPITALMAN HERMAN LEE BROWN WAS BORN ON 18 NOVEMBER 1953 IN THE CITY OF BLACKVILLE, SOUTH CAROLINA. A GRADUATE OF BLACKVILLE-HILDA HIGH SCHOOL, BLACKVILLE, SOUTH CAROLINA, HOSPITALMAN BROWN ALSO SERVED WITH THE UNITED STATES ARMY RESERVE. HOSPITALMAN BROWN ENLISTED IN THE UNITED STATES NAVY ON 15 MARCH 1982. AFTER UNDERGOING RECRUIT TRAINING IN SAN DIEGO, CALIFORNIA, HOSPITALMAN BROWN THEN ATTENDED HOSPITAL CORPS SCHOOL IN THAT SAME CITY. AFTER FINISHING HOSPITAL CORPS SCHOOL, HOSPITALMAN BROWN WAS THEN SENT TO FIELD MEDICAL SERVICE SCHOOL, CAMP PENDLETON, CALIFORNIA. HOSPITALMAN BROWN WAS SUBSEQUENTLY SENT TO NAVAL REGIONAL MEDICAL CENTER, CAMP LEJEUNE, NORTH CAROLINA.

Camp Lejeune's New Hospital

Story and photos by P. L. Thompson

Located on a 162-acre site, the new medical facility is expected to handle more than 8,000 admissions a year and more than 540,000 outpatient visits.

Marine Corps Base, Camp Lejeune, N.C., is now the home of an ultra-modern, $45.3 million Naval Regional Medical Facility, offering treatment and services to the military community of the base and the surrounding area.

The 205-bed hospital, with its extensive outpatient facilities, is located on a sprawling 162-acre site near the intersection of Stone Street and Brewster Boulevard at Camp Lejeune.

Navy Lt David A. Wynkoop, the Medical Construction Liaison Officer, is proud of the new facility. "The contract for the hospital was brought in on time and on budget and we accomplished the move from our old hospital to the new one in a little less than five days," he said.

"We opened our doors for business the morning of Tuesday, February 15, 1983. In fact, the first baby was born in one of our three delivery rooms on the Saturday before we were officially open," Wynkoop pointed out.

The new medical facility will offer many advanced features for the comfort, treatment and care of patients.

"We now offer private and semi-private rooms, or those with four beds, depending on the needs of the patients. The hospital has 205 beds, but it can be expanded to accept 236 if the need should arise.

"The new facility features an Energy Monitoring and Control System (EMCS), which is the largest and most extensive computer-based distributive process building control system ever installed in a Naval shore facility," related Wynkoop. The EMCS can transfer heat or air-conditioning from one part of the building to where it is needed the most, maintaining a constant and comfortable temperature," he added.

The EMCS is programmed to know that the outpatient facility closes at a certain hour. At the proper time, the computer will shut down the heat and lights to that part of the building and warm it up again the next morning.

The computer is also used for security purposes and it has a complete communications system which enables it to play background music in the public areas of the hospital.

"Most importantly, the computer also handles our fire alarm system. It has the ability, when smoke is detected, to create a negative air pressure within the building that prevents the fire from spreading," said Wynkoop.

Although initially expensive, the EMCS system was designed to handle its different functions as a cost-saving factor. Lt Wynkoop believes the system will pay for itself in energy savings alone.

Another unique feature of the new hospital's design is the regulation of traffic flow within the building.

"One of the problems we had with the old hospital was moving our staff through areas that contained a large

Civilian Guidepost

Compiled and Edited by
CIVILIAN PERSONNEL DIVISION, MARINE CORPS BASE, CAMP LEJEUNE, NORTH CAROLINA
Issuance of this periodical approved in accordance with Department of the Navy Publications and Printing Regulations
VOLUME 28 NO. 12. 17 June 1983

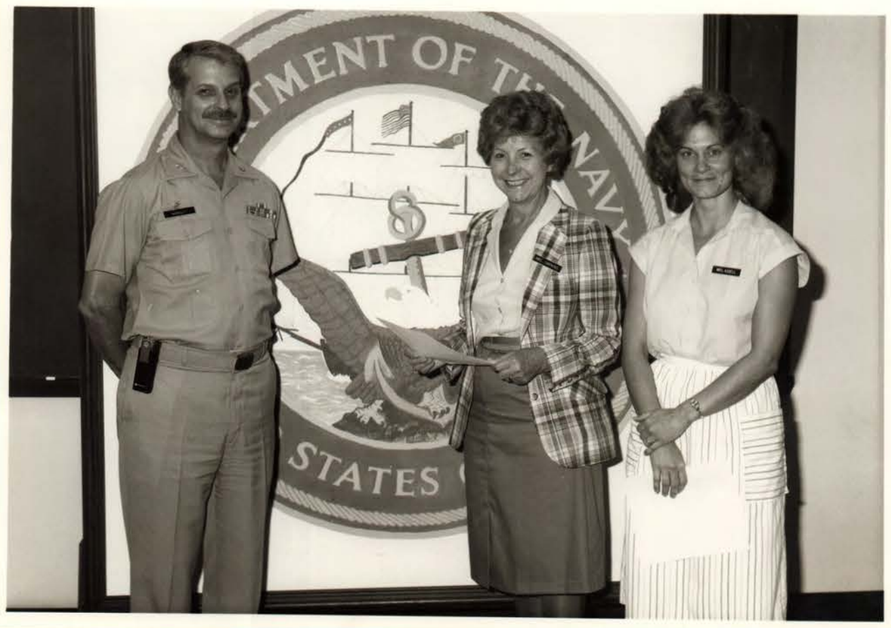
BENEFICIAL SUGGESTION WINNER

Captain J. D. Marriott, MC, USN, Commanding Officer, Naval Regional Medical Center, recently presented a Beneficial Suggestion award to Mrs. Mary F. Garner. Mrs. Garner received a cash award of $300 for her suggestion to revise the Navy Performance Appraisal Form NAVSO 12430/9 so that all information would fit on one 8½" x 11" page with Performance Standards attached to that page, eliminating additional typing of the standards. The award was based on moderate first year savings with a broad extent of application.

Mrs. Garner was given a "Beneficial Suggestion Winner" coffee mug in addition to her certificate and check.

If you too would like to be a "Beneficial Suggestion Winner," submit a Beneficial Suggestion today! If you need a suggestion form, ask your supervisor or call extension 1458 or 1579.

PERSONNEL INSPECTION - 29 JULY 1983



OUTSTANDING CERTIFICATES -
OUTPATIENT ADMIN/MEDICAL RECORDS -

BILLY SIMPKINS AND NANCY ASBELL -
16 AUGUST 1983

OUTSTANDING CERTIFICATES - SOCIAL
WORK: SUSAN DEERING AND ROGER
NORRIS - 16 AUGUST 1983

OUTSTANDING CERTIFICATES - PATIENT ADMINISTRATION: CONSTANCE FERGUSON, DIANA HOBBS, DIANA DUNN, LINDA CHOWAT, JOAN ENNETT, NANCY THOMAS, MARY WHALEY, MARY FINLEY, WARREN WHALEY - 16 AUGUST 1983

OUTSTANDING CERTIFICATES - OCCUPATIONAL AND PREVENTIVE MEDICINE: EUGENE ENNIS AND JOHN MCCLOSKEY - 16 AUGUST 1983

OUTSTANDING CERTIFICATES - PHARMACY: NANCY ELLIOTT, SANDRA BREESE, ERIKA KNOWLTON - 16 AUGUST 1983

OUTSTANDING CERTIFICATES - BUILDING 15, BRANCH CLINICS: THETA LAMBERT, EDGAR GALBRAITH, WILLIE TROWELL - 16 AUGUST 1983

OUTSTANDING CERTIFICATES - NURSING SERVICE: MARY COVELLA, EVELYN PARKER, LANNIE THOMAS, RUTH BROADHEAD GEORGIANA MCNAIR - 16 AUGUST 1983

OUTSTANDING CERTIFICATES - OFFICE OF THE COMMANDING OFFICER: NANCY HALL, DORIS GASKINS, GLENDA PROVOST

16 AUGUST 1983

OUTSTANDING CERTIFICATES- FISCAL DIVISION - COLLEEN WRIGHTSMAN, KATE PARKER, WILLIAM BASS - 16 AUGUST 1983

BERNICE MIKEAL - LETTER OF COMMENDATION - 16 AUGUST 1983

OUTSTANDING CERTIFICATE - MARY GARNER - 16 AUGUST 1983

OUTSTANDING CERTIFICATES - OPERATING MANAGEMENT DIVISION - 16 AUGUST 1983 VICKY CHASTEN, DAVID POINTE, EMMA KATIE SIMS, FREDERICK WHITE, WINSTON MURPHY, JAMES WHITE, BRAD WRIGHT, GEORGE MALLCHECK, JAMES LONG, NATHANIEL GREEN, MORRIS DIXON

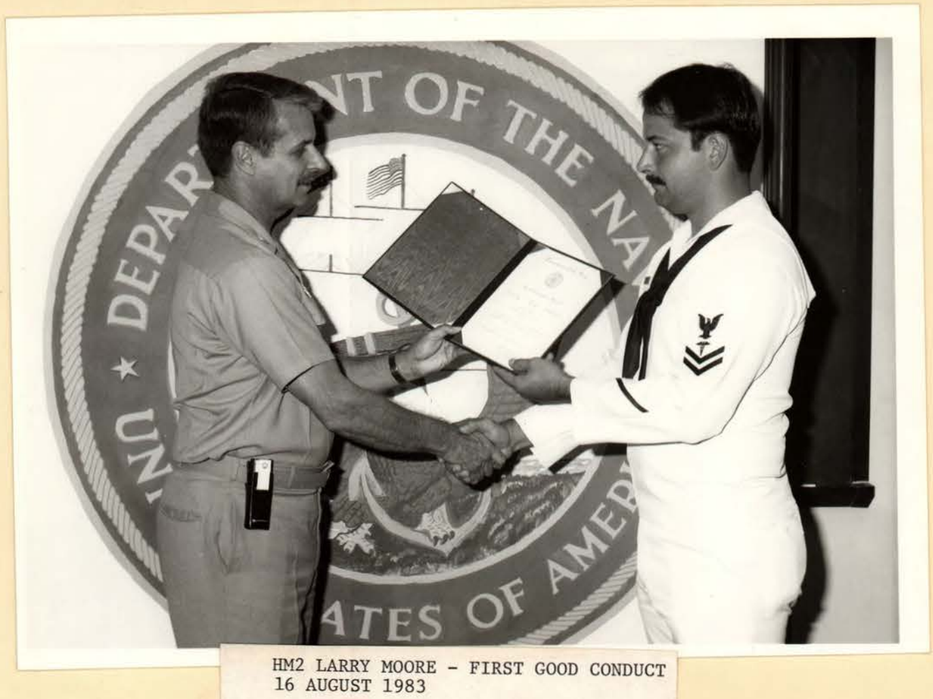
OUTSTANDING CERTIFICATES - DEBORAH SEIPEL AND MARY BURNS - 16 AUGUST 1983

O. D. MATLOCK - OUTSTANDING CERTIFICATE - 16 AUGUST 1983

BENEFICIAL SUGGESTION AWARD - MARY GARNER - JUNE 1983

OUTSTANDING CERTIFICATE - DORIS DUFFY - 16 AUGUST 1983

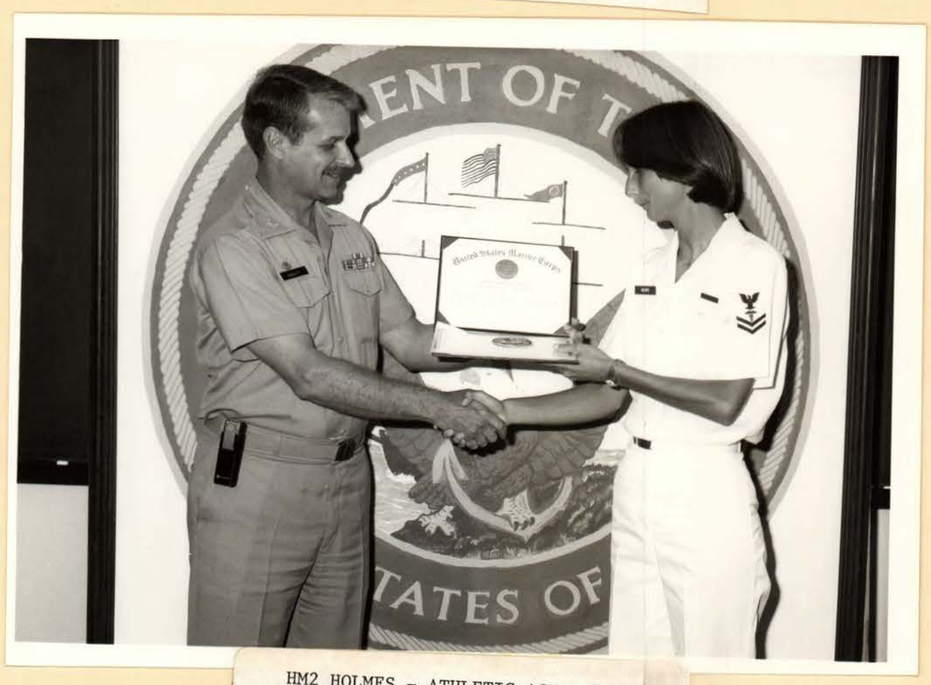
HM3 FREER - FIRST GOOD CONDUCT - 16 AUGUST 1983



HM2 LARRY MOORE - FIRST GOOD CONDUCT
16 AUGUST 1983

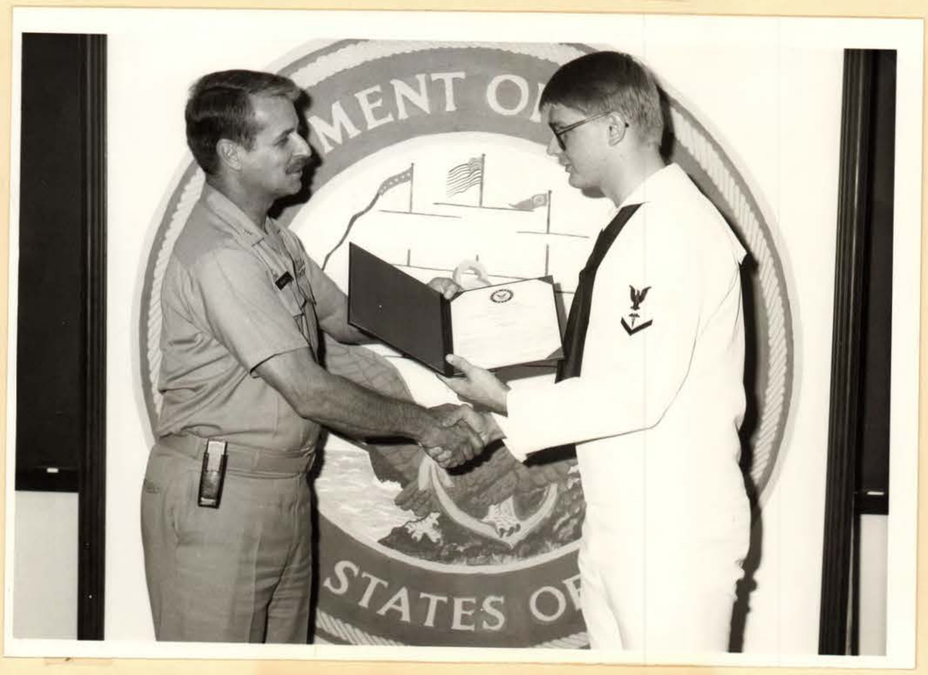
HM3 BAILY - CERTIFICATE OF
COMMENDATION - 16 AUGUST 1983

HM3 DAVID REINHART - ADVANCEMENT
TO HM3 - 16 AUGUST 1983

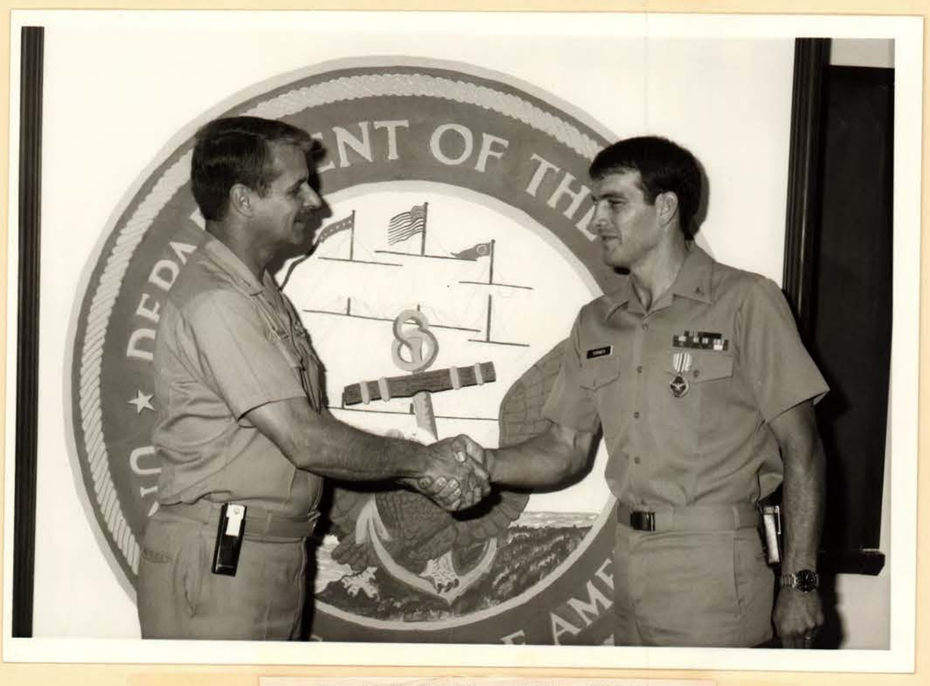


HM2 HOLMES - ATHLETIC ACHIEVEMENT -
16 AUGUST 1983

LTJG MEIBOOM - AIR FORCE
COMMENDATION - 16 AUGUST 1983

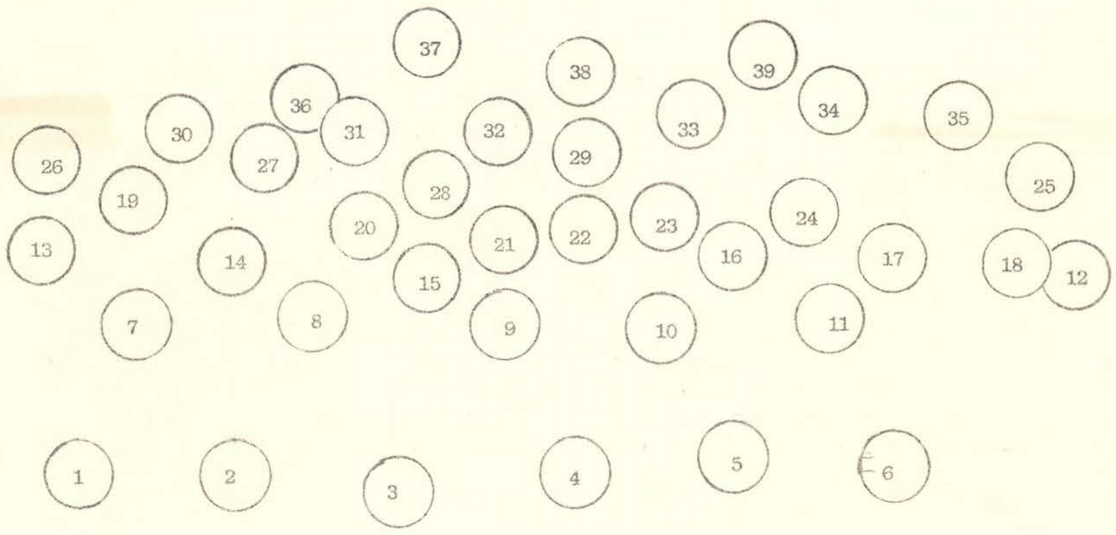


HM3 MARK MACFADZEN - GOOD CONDUCT
MEDAL - 16 AUGUST 1983

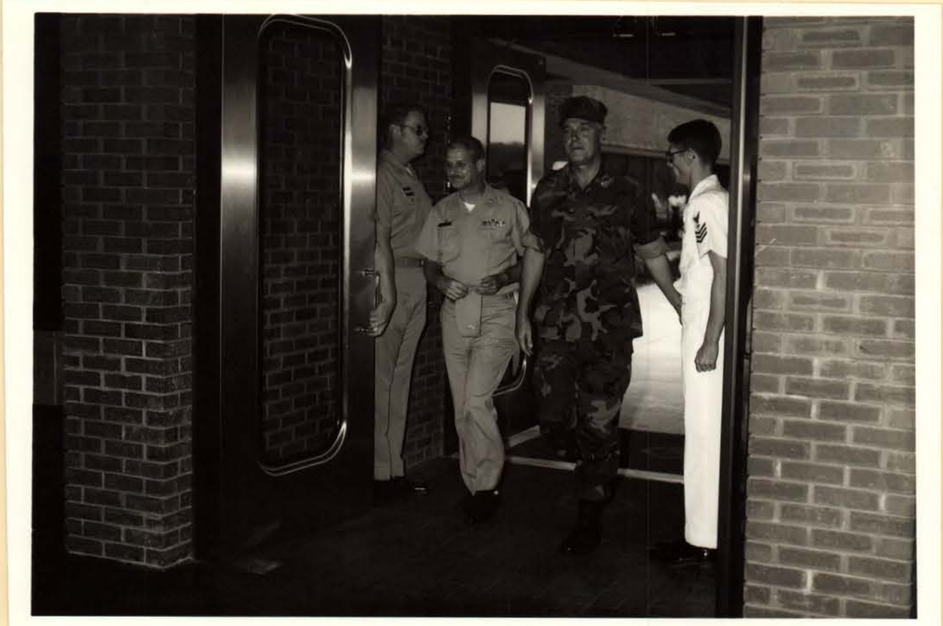


ENS BRAD TURNER - JOINT SERVICE
COMMENDATION - 16 AUGUST 1983

36TH ANNIVERSARY OF THE MEDICAL SERVICE CORPS - 1983



1. CAPT R. SKELLY
2. CAPT E. STEWARD (RET)
3. LT R. SMITH (RET)
4. CAPT N. DENISON
5. CDR K. FLOAN (RET)
6. CDR P. CAMPBELL
7. LDCR W. ROYALS (RET)
8. LCDR M. MARTIN (RET)
9. LTJG R. GRIFFITH
10. LCDR J. DENAYER
11. LCDR J. PARKS
12. LCDR W. McCOY
13. LT. R. SMITH
14. LT. J. REIBLING
15. LCDR F. CONROE
16. LCDR H. McNAIR
17. ENS R. KOPENHAVER
18. LTJG M. NEELEY
19. LTJG T. SULLIVAN
20. ENS F. BOURRIE
21. ENS S. McGIVERN
22. LCDR P. AMMONS
23. LCDR C. HOOTEN
24. LT C. MEGOWN
25. LCDR V. RENNER
26. LTJG M. SCHWALM
27. LCDR B. UPTON
28. LT J. ANDORFER
29. LCDR L. ROACH
30. LT J. BOYD
31. LT R. FLETCHER
32. LT R. ROBERTS
33. LT P. BARRETT
34. LT C. HANSEN
35. LT J. GREENAUER
36. ENS D. McPHERSON
37. LTJG C. GUNN
38. LCDR J. SOLIDAY
39. ENS R. SMITH



ADMIRAL JAMES D. WATKINS, USN,
CHIEF OF NAVAL OPERATIONS VISITS
CAMP LEJEUNE - 25 AUGUST 1983